HEALTH HISTORY FORM

advanced
ORTHODONTIC SPECIALISTS
MICHAEL BICKNELL, DDS, MS

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname _____ Birthdate _____ Social Security # _____

School _____ Sports/Hobbies _____

Parent or guardian name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work phone _____

Cell/Other Phone _____ Email Address _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthday _____ Work phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? ❑ Yes ❑ No If yes: _____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

Parent Signature _____

Updates (date & initial) _____

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MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please check Yes or No (If Yes, please fill in details)

❑ Yes ❑ No Is the patient taking any medication? _____

❑ Yes ❑ No Is the patient allergic to any medication? _____

❑ Yes ❑ No History of a major illness? _____

❑ Yes ❑ No Has the patient had any operations? _____

❑ Yes ❑ No Ever been involved in a serious accident? _____

❑ Yes ❑ No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

❑ Yes ❑ No Has menstruation started? _____

❑ Yes ❑ No Is the patient pregnant? _____

Check any of the medical conditions below that you have had or currently have.

❑ Abnormal bleeding/Hemophilia	❑ Diabetes	❑ Hepatitis/Liver problems	❑ Pneumonia	❑ Anemia
❑ Radiation/Chemotherapy	❑ Dizziness	❑ Herpes	❑ Prolonged Bleeding	❑ Arthritis
❑ High Blood Pressure	❑ HIV/Aids	❑ Rheumatic Fever	❑ Asthma or Hayfever	❑ Bone Disorders
❑ Gastrointestinal Disorders	❑ Heart Problems	❑ Kidney problems	❑ Tuberculosis	❑ Epilepsy
❑ Congenital Heart Defect	❑ Heart Murmur	❑ Nervous Disorders	❑ Tumor or Cancer	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

❑ Yes ❑ No Is the patient presently in any dental pain? _____

❑ Yes ❑ No Ever experienced any unfavorable reaction to dentistry? _____

❑ Yes ❑ No Has the patient ever seen an orthodontist? If yes, who and when? _____

❑ Yes ❑ No Has the patient ever lost or chipped any teeth? _____

❑ Yes ❑ No Have there been any injuries to face, mouth, or teeth? _____

❑ Yes ❑ No Is any part of your mouth sensitive to temperature? Where? _____

❑ Yes ❑ No Is any part of your mouth sensitive to pressure? Where? _____

❑ Yes ❑ No Do gums bleed when brushing? _____

❑ Yes ❑ No Any type of thumb or tongue habit? _____

❑ Yes ❑ No Is the patient a mouth breather? _____

❑ Yes ❑ No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____

❑ Yes ❑ No Experience jaw clicking or popping? _____

❑ Yes ❑ No Aware of clenching or grinding teeth during the day? _____

❑ Yes ❑ No Experience "tension" headaches? _____

❑ Yes ❑ No Has the patient ever experienced chronic ringing in the ears? _____

❑ Yes ❑ No Is the patient sensitive or self-conscious about his/her teeth? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Michael Bicknell to perform a complete orthodontic evaluation.

Signature: _____ Date: _____