Health History

Patient's Name:	DOB:	Date:

Is patient allergic to any of the following?

	Yes	No	If yes, Explain
Latex	☐	☐	
Any Metals/Jewelry	☐	☐	
Aspirin	☐	☐	
Dental Anesthetics	☐	☐	
Penicillin	☐	☐	
Clindamycin	☐	☐	
Erythromycin	☐	☐	
Any other?	☐	☐	

Does patient have, or ever had any of the following?

	Yes	No	If yes, Explain
Abnormal Bleeding	☐	☐	
Abnormal Blood Pressure	☐	☐	
Anemia	☐	☐	
Artificial Bones/Joints/Valves	☐	☐	
Asthma	☐	☐	
Bisphosphonate Therapy	☐	☐	
Cancer/Chemotherapy	☐	☐	
Diabetes/Tuberculosis	☐	☐	
Epilepsy/Seizures	☐	☐	
Fainting	☐	☐	
Fever Blisters/Herpes	☐	☐	
Heart Condition	☐	☐	
Heart Murmur	☐	☐	
Hepatitis	☐	☐	
Kidney/Liver Problems	☐	☐	
Positive HIV Test	☐	☐	
Radiation Treatment	☐	☐	
Rheumatic Fever	☐	☐	
Venereal Disease	☐	☐	
Hospitalized for any Reason	☐	☐	
Might be pregnant?	☐	☐	
Other Medical Condition	☐	☐	

Any Habits?	Yes	No	If yes, Explain
Clenching/Grinding Teeth	☐	☐	
Lip Sucking/Biting	☐	☐	
Mouth Breather	☐	☐	
Nail Biting	☐	☐	
Nursing Bottle Habits	☐	☐	
Speech Problems	☐	☐	
Thumb/Finger Sucking	☐	☐	
Tongue Thrust	☐	☐	

Medical Information:

Is patient currently under the care of a physician? ☐ Yes ☐ No

Please Explain

What is the name of patient's regular physician?

Physician's Name Phone Number Last Visit

Is patient taking prescription/over-the-counter drugs? ☐ Yes ☐ No

Please List

Dental Information:

What is the name of patient's General Dentist?

Dentist's Name Phone Number Date of Last Visit

What was done on last dental visit?

Please List

Does patient have ever experienced pain in jaw joint(TMJ/TMD)? ☐ Yes ☐ No

Has there been any injury to patient's mouth, chin or teeth? ☐ Yes ☐ No

What are the main concerns that you would like orthodontics/braces to accomplish?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform any necessary dental services that I/my child may need during diagnosis and treatment with my informed consent.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's orthodontic care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

Patient/Parent Signature Date

I verbally reviewed Medical / Dental information with the patient named herein.

Comments

Doctor's Signature Date

(Please Fill This Section ONLY When Updating In Future)

I certify that there has been no changes in above information.

Patient/Parent Signature Date

Doctor's Signature Date