Thunderbird
Kid's Dentistry & Orthodontics

CHOICE
HEALTHCARE SERVICES
AFFILIATE

# Patient Health History Form

## Patient

Date: _____ How did you hear about our office? _____
Patient's first name: _____ Middle initial: _____ Last name: _____ Nickname: _____
Birthdate: _____ Sex: ___ Male ___ Female Social Security Number # _____
Hobbies, activities: _____
Home address: _____ City, State, Zip code: _____
Cell phone: _____ Home phone: _____
Work Phone: _____ Email address(es): _____

## Parent/Guardian

Custodial parent(s) name (s): _____
Patient lives with (mark all that apply) ___ Mother ___ Father ___ Stepmother ___ Stepfather ___ Grandparent(s) ___Other

## Dentist

Patient's dentist: _____ Address, City, State: _____
Last seen: _____ Reason: _____ Next appointment: _____
Other dentists/ dental specialists now being seen: Name: _____ City, State_____

## General Information

What concerns do you have about your teeth? _____

Have any other family members been treated in this office? _____If yes, please name them: _____
_____
Have you had any previous orthodontic treatment? _____ If yes, please describe: _____
_____
Why did you select our office? _____

## Dental Insurance

Insurance Company: _____ Phone #: _____
Primary policy holder's full name: _____ Birthdate: _____
Member or Subscriber ID #: _____ Group #: _____

Social Security #: _____ Relationship Patient: _____

Policy Holders Address: _____ City, State, Zip code: _____
Employer: _____ Employer Address: _____
Does this policy have orthodontics benefits? _____ YES _____ NO _____I don't know

Secondary Insurance Company: _____ Phone #: _____
Secondary policy holder's full name: _____ Birthdate: _____
Member or Subscriber ID #: _____ Group #: _____

Social Security #: _____ Relationship Patient: _____

Policy Holders Address: _____ City, State, Zip code: _____
Employer: _____ Employer Address: _____
Does this policy have orthodontics benefits? _____ YES _____ NO _____ I don't know

**Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. For the following questions mark "yes", "no", or "not sure".**

## Medical history

**Now or in the past, have you had:**

__ YES __ NO __ Not sure Birth defects or hereditary problems?
__ YES __ NO __ Not sure Bone fractures, or major injuries?
__ YES __ NO __ Not Sure Any injuries to face, head or neck?
__ YES __ NO __ Not Sure Arthritis or joint problems?
__ YES __ NO __ Not Sure Cancer, tumor, radiation treatment or chemotherapy?
__ YES __ NO __ Not Sure AIDS or HIV positive?
__ YES __ NO __ Not Sure Hepatitis, jaundice or other liver problem?
__ YES __ NO __ Not Sure Polio, mononucleosis, tuberculosis, pneumonia?
__ YES __ NO __ Not Sure Seizures, fainting spells, neurologic problem?
__ YES __ NO __ Not sure Vision, hearing, or speech problems?
__ YES __ NO __ Not sure History of eating disorder (anorexia, bulimia)?
__ YES __ NO __ Not sure High or low blood pressure?
__ YES __ NO __ Not sure Excessive bleeding or bruising, anemia?
__ YES __ NO __ Not sure Heart defects, heart murmur, rheumatic heart disease
__ YES __ NO __ Not sure Angina, arteriosclerosis, stroke or heart attack?
__ YES __ NO __ Not sure Frequent headaches or migraines?
__ YES __ NO __ Not sure Frequent ear infections, colds, throat infections?
__ YES __ NO __ Not sure Do you frequently breathe through your mouth?

**Have you had allergies or reactions to any of the following:**

__ YES __ NO __ Not sure Latex (gloves, balloons)

__ YES __ NO __ Not sure Metals (jewelry, clothing snaps)

__ YES __ NO __ Not sure Acrylics
__ YES __ NO __ Not sure Local anesthetics (Novocaine, lidocaine, xylocaine)

__ YES __ NO __ Not sure Aspirin
__ YES __ NO __ Not sure Ibuprofen (Motrin, Advil)
__ YES __ NO __ Not sure Penicillin
__ YES __ NO __ Not sure Other antibiotics
__ YES __ NO __ Not sure Plant pollens
__ YES __ NO __ Not sure Animals
__ YES __ NO __ Not sure Foods
__ YES __ NO __ Not sure Other substances

## Dental History

**Now or in the past have you had**:

__ YES __ NO __ Not sure Permanent or extra (supernumerary) teeth removed?
__ YES __ NO __ Not sure Supernumerary (extra) or congenitally missing teeth?

__ YES __ NO __ Not sure Chipped or injuries primary or permanent teeth?
__YES __ NO __ Not sure Any sensitive or sore teeth?
__ YES __ NO __ Not sure Bleeding gums, bad taste, or mouth odor?
__YES __ NO __ Not sure Jaw fractures, cysts, infections?
__ YES __ NO __ Not sure Any teeth treated with root canals or pulpotomies?
__ YES __ NO __ Not sure History of speech problems or speech therapy?
__ YES __ NO __ Not sure Food impaction between teeth?
__ YES __ NO __ Not sure Mouth breathing habit or snoring at night?
__ YES __ NO __ Not sure Frequent oral habits (sucking finger, chewing pen, etc.)?
__ YES __ NO __ Not sure Teeth causing irritation to lip, cheek or gums?
__ YES __ NO __ Not sure Abnormal swallowing (tongue thrust)?
__ YES __ NO __ Not sure Tooth grinding or clenching?
__ YES __ NO __ Not sure Clicking, locking in jaw joints?
__ YES __ NO __ Not sure Soreness in jaw muscles or face muscles?

__ YES __ NO __ Not sure Ringing in ears, difficulty in chewing or opening jaw?
__ YES __ NO __ Not sure Have you ever been diagnosed with gum disease or pyorrhea?
__ YES __ NO __ Not sure Have you ever had an orthodontic consultation or treatment before

## Patient Health Information

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take: _____

Do you take antibiotic pre-medication before any dental procedures? ____ YES ____ NO

Have you smoked any substance or vaped? ____YES ____ NO If yes, what is the frequency? _____

Have you chewed tobacco ____ YES ____ NO Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush?: _____ How often do you floss?: _____

Women: Are you pregnant? ____ YES ____ NO Are you trying to become pregnant? ____YES ____ NO

## Release and Waiver

I authorize release of any information regarding my orthodontics treatment to my dental and/ or medical insurance company.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Printed Name: _____ Signature: _____ Date: _____