New Patient Health History

Patient Biographical Information

Date:			
First Name:	Middle Initial:	Last Name:	Nickname:
Birthdate:			Gender:
Address:	City:	State:	Zip:
Home Phone:	Work Phone:		Cell Phone:
Patient's Email:			

Contact Information

I prefer to be contacted by:

- ❑ Cell Phone: _____
- ❑ Home Phone: _____
- ❑ Email: _____
- ❑ Other: _____

- ❑ Morning (8am – noon)
- ❑ Midday (noon – 3pm)
- ❑ Late afternoon (3pm – 6pm)

Referral Information

Please list the names of any friends or family currently in the practice:

Who may we thank for referring you to our practice?

Please let us know of the ways you are familiar with Team Demas Orthodontics: (Please check all that apply)

- ❑ Family Dentist/Physician referral: _____
- ❑ Friend / Patient referral: _____
- ❑ Team Demas staff referral: _____
- ❑ Invisalign / SureSmile web search
- ❑ Website
- ❑ School referral
- ❑ Mail Postcard
- ❑ Ad at school
- ❑ Print ad
- ❑ Community Event
- ❑ Sports Team Sponsorship
- ❑ Drive by / Signage
- ❑ Other: _____

Financial Party Information

First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Length of time at above address:		Rent or own at current address:	
Previous Address (if less than 3 yrs):			
Home Phone:	Work Phone:		Cell Phone:
Social Security #:	Relationship to Patient:		
Employer:	Length of Employment:		Occupation:
Spouse's Name:		Spouse's Occupation:	
Spouse's Work Phone:		Spouse's Cell Phone:	
Parent's marital status: Married Separated Divorced Single Widowed			
With whom does patient reside?	Legal Guardian:		
Insurance Company Name:			
Group Number:	Subscriber:		
ID Number:	Insurance Company Address and Phone Number:		

Dental History

Dentist Name:			
Check-up Frequency:		Last Dental Cleaning:	
Has the patient had an orthodontic consult or treatment? Yes No		If so, when?	
What is the patient's main orthodontic concern?			

Speech problems/therapy?	Yes	No	Brush teeth daily?	Yes	No
Grind or clench teeth at night or habitually?	Yes	No	Floss teeth daily?	Yes	No
Oral habits (thumb/finger habit, lip/nail biting)?	Yes	No	Use fluoride rinse daily?	Yes	No
Injury to face, jaw, teeth, or mouth?	Yes	No	Mouth breathing?	Yes	No
Discomfort from teeth or gums?	Yes	No	Snores during sleep?	Yes	No
Pain in or near your ears?	Yes	No	Premedication before dental treatment?	Yes	No
Frequent headaches?	Yes	No	Any missing or extra permanent teeth?	Yes	No
Neck/shoulder pain?	Yes	No	Apprehensive about dental care?	Yes	No
Frequent sore throats?	Yes	No	Frequently chews gum?	Yes	No
Constant sore or bleeding gums?	Yes	No	Had any teeth removed?	Yes	No
Difficulty chewing or swallowing food?	Yes	No	Clicking jaw joint when opening/closing?	Yes	No
			Pain or tenderness in either jaw?	Yes	No

If any of the above dental questions were answered "Yes," please explain:

Does patient play a musical instrument with his/her mouth? If yes, please list all:

Medical History

Physician Name:	Date of last Physical:	Patient Health:	
Address:	City:	State:	Zip:

Is patient presently under a physician's care? If yes, please explain:

List any medications currently being taken by the patient:

List drug allergies, latex allergy, or sensitivity:

Rheumatic Fever	Yes	No	Cancer	Yes	No
Tuberculosis/Lung Disease	Yes	No	Family History of Cancer	Yes	No
Pneumonia	Yes	No	Received Radiation Treatment	Yes	No
Liver Disease	Yes	No	Growth Problems	Yes	No
Kidney Disease	Yes	No	Endocrine Problems	Yes	No
Heart Attack/Stroke	Yes	No	Hormone Therapy	Yes	No
Heart Disease	Yes	No	Latex/Metal Allergy	Yes	No
Congenital Heart Defect	Yes	No	Nervous Disorders	Yes	No
Heart Murmur	Yes	No	Bone Disorders/Bone Loss	Yes	No
Hemophilia	Yes	No	Diabetes	Yes	No
Hypertension/High Blood Pressure	Yes	No	Seizures/Epilepsy	Yes	No
Prolonged Bleeding/Transfusion	Yes	No	Handicaps/Disabilities	Yes	No
Anemia	Yes	No	Asthma	Yes	No
HIV/AIDS	Yes	No	Rheumatism or Arthritis	Yes	No
Hepatitis	Yes	No	Treated for Emotional Problems	Yes	No
Venereal Disease	Yes	No	Ever Been Hospitalized	Yes	No
Blood Disease	Yes	No	Ever Had Extensive X-ray Therapy	Yes	No
Tumors or Growths	Yes	No	Tonsils/Adenoids Removed	Yes	No
Stomach or Intestinal Disease	Yes	No	Operations or Injuries of Head or Neck	Yes	No
Yellow Jaundice or Hepatitis	Yes	No	History of fainting	Yes	No
Night Sweats accompanied by weight loss/cough	Yes	No	Currently dieting	Yes	No
Wounds heal slowly / present complications	Yes	No	If female, are you pregnant	Yes	No

Other, if so, please explain?

If any of the above medical questions were answered "Yes," please explain:

Has patient been ill for more than 5 days in the last year? If yes, please explain:

Allergic to any known materials resulting in hives, asthma, eczema, etc? If yes, please explain:

Signature: _____ Date: _____

Patients Under 18		
Please list the name and birthdates of any siblings:		
School:		Grade:
Father/Guardian Name:	Mother/Guardian Name:	
Father/Guardian Email:	Mother/Guardian Email:	
Father's Height:	Mother's Height:	

Is patient adopted?	Yes	No	
Has patient begun puberty?	Yes	No	
If patient is a girl, has menstruation begun?	Yes	No	Age:
If patient is a boy, has their voice changed or have facial hair?	Yes	No	
Has the patient experienced a sudden increase in height?	Yes	No	
Does any member of the family or close relatives have similar arrangement of teeth or jaws?	Yes	No	
Has any member of the family had orthodontic treatment?	Yes	No	

Who first noticed the need for orthodontic treatment?

❑ Parents ❑ Dentist ❑ Patient ❑ Other: _____

Are the parents interested in having orthodontic treatment:

❑ for appearance ❑ better digestion ❑ better speech ❑ advice of dentist ❑ advice of friends

Are the parents aware that some appointments may infringe minimally on school time?	Yes	No
Is the patient concerned about the appearance of his/her teeth?	Yes	No
Has the patient ever been teased about the appearance of his/her teeth?	Yes	No
Is the patient aware of/or concerned about his/her orthodontic problem?	Yes	No

What is the patient's attitude toward wearing orthodontic appliances?

❑ Eagerness ❑ Willingness ❑ Complacency ❑ Resignation ❑ Antagonism

Signature: _____ Date: _____

Doctor Signature: _____ Date Reviewed: _____