New Patient Health History – Team Demas Orthodontics

Date: _____________

Patient Biographical Information			
First Name:	Last Name:	Nickname:	Adopted? Yes No
Birthdate:	Gender:	Home Phone:	
Address:	City:	State:	Zip:

Financial Party Information			
First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Previous Address (if less than 3 yrs):			
Employer:	Length of Employment:	Occupation:	
Father/Guardian Name:	Mother/Guardian Name:		
Father/Guardian Email:	Mother/Guardian Email:		
Father's Occupation:	Mother's Occupation:		
Father's Cell #:	Mother's Cell #:		
Father's Height:	Mother's Height:		
With whom does patient reside?	Legal Guardian/Custodian:		
Parent Marital Status (if <18): ❑ Married / Re-married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed			
Please list the name(s) and birthdate(s) of any siblings:			

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: ____________________________

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	Floss teeth daily?	Yes	No
Grind/clench teeth habitually?	Yes	No	Injury to face/jaw/teeth/mouth?	Yes	No	Use fluoride rinse daily?	Yes	No
Oral finger/thumb/nail biting habits?	Yes	No	Mouth breathing?	Yes	No	Snores during sleep?	Yes	No
Discomfort in teeth or gums?	Yes	No	Pain in/near your ears?	Yes	No	Frequent headaches?	Yes	No
Premedication before dental treatment?	Yes	No	Neck/shoulder pain?	Yes	No	Frequently chews gum?	Yes	No
Any missing or extra permanent teeth?	Yes	No	Frequent sore throats?	Yes	No	Had any teeth removed?	Yes	No
Constant sore or bleeding gums?	Yes	No	Difficulty chewing/swallowing food?	Yes	No	Clicking jaw joint?	Yes	No
Apprehensive about dental care?	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:

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

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:

Patients Under 18

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	

Who first noticed the need for orthodontic treatment?
❑ Parents ❑ Dentist ❑ Patient ❑ Other: ______________________________

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

What is the patient's attitude toward wearing orthodontic appliances?
❑ Eagerness ❑ Willingness ❑ Complacency ❑ Resignation ❑ Antagonism

Signature: ________________________________ Date: ____________________

Print Name: ________________________________ Relationship to Patient (if <18yr old): ____________________

Doctor Signature: ________________________________ Date Reviewed: ______________