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

Father/Guardian Name:	Mother/Guardian Name:
Father/Guardian Address if different from above:	Mother/Guardian Address if different from above:
Father's Occupation/Employer:	Mother's Occupation/Employer:
With whom does patient reside?	Legal Guardian/Custodian:
Parent Marital Status (if <18): ❑ Married / Re-married ❑ Separated ❑ Divorced ❑ Single ❑ Widowed	
Father/Guardian Email: Want appt reminder? Yes No	Mother/Guardian Email: Want appt reminder? Yes No
Father/Guardian Cell #: Want appt reminder? Yes No	Mother/Guardian Cell #: Want appt reminder? Yes No
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: _____	❑ School referral	❑ Community Event
❑ Friend / Patient referral: _____	❑ Mail Postcard	❑ Sports Team Sponsorship
❑ Team Demas staff referral: _____	❑ Ad at school	❑ Drive by / Signage
❑ Invisalign web search	❑ Print ad	❑ Other: _____
❑ Website		

Dental History

Dentist Name:

Check-up Frequency:	Last Dental Cleaning:

Speech problems/therapy?	Yes No	Frequently chews gum?	Yes No	Clicking jaw joint?	Yes No
Grind/clench teeth habitually?	Yes No	Injury to face/jaw/teeth/mouth?	Yes No	Had any teeth removed?	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	**Oral Hygiene Habits**	
Any missing or extra permanent teeth?	Yes No	Frequent sore throats?	Yes No	Brush teeth daily?	Yes No
Constant sore or bleeding gums?	Yes No	Difficulty chewing/swallowing food?	Yes No	Use fluoride rinse daily?	Yes No
Apprehensive about dental care?	Yes No	Pain or tenderness in either jaw?	Yes No	Floss teeth daily?	Yes No

If any of the above dental questions (not including Oral Hygiene Habits) were answered "Yes," please explain:

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

Patient Name: _____

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:

Father's Height:	Mother's Height:

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:

Orthodontic History

Has the patient had an orthodontic consult or treatment? Yes No If so, when?

What is the main orthodontic concern?

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

Please rank the order of importance in your selection of orthodontic treatment, with 1 being "highest importance" and 4 being "least importance".
___ Results ____ Financial Arrangements ___ "Clear" treatment options – Invisalign or clear braces ___ Doctor / Staff Experience

Patients Under 18

For girls, has menstruation begun? Yes No Age: _____

For boys, has their voice changed or have facial hair? Yes No Age: _____

Has the patient experienced a sudden increase in height? Yes No

Signature: _____ Date: _____

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

Doctor Signature: _____ Date Reviewed: _____