DIABLO
ORTHODONTIC SPECIALISTS

Confidential Health History

Patient Biographical Information					
First Name:	Middle Initial:	Last Name:		Nickname:	
Birthdate:	Gender:		Social Security #:		
Address:	City:		State:	Zip:	
Main Phone:	Cell Phone:		Email:		
Please list the names of any friends or family currently in the practice:					
List any sports, hobbies, or musical instruments played:					
Whom may we thank for referring you to our practice?					
We love INVISALIGN!! Do you have any interest in either Invisalign or clear braces? Yes No					
Most appointments are confirmed via text messages. May we text you reminders? Yes No					

Dental History			
Dentist Name:			
Check-up Frequency:		Last Dental Visit:	
Ever had a previous orthodontic consult? Yes No		If so, when?	
What is your main orthodontic concern?			
Speech problems/therapy?	Yes No	Brush teeth daily?	Yes No
Grind or clench teeth?	Yes No	Floss teeth daily?	Yes No
Habits (thumb/finger, lip/nail biting)?	Yes No	Fluoride treatments?	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, tenderness, or noise in either jaw?	Yes No	Requires premedication?	Yes No
Frequent headaches?	Yes No	Any missing or extra teeth?	Yes No
Neck/shoulder pain?	Yes No	Apprehensive about dental care?	Yes No
Frequent sore throats?	Yes No	Frequently chews gum?	Yes No
If any of the above dental questions were answered “Yes,” please explain:			

Medical History			
Physician Name:	Date of last Physical:	Patient Health:	
Address:	City:	State:	Zip:
List any medications patient is currently taking:			
List any drug allergies or sensitivities that patient may have:			

Has patient ever had any of the following conditions? Please answer each response separately.			
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	Bisphosphonate Therapy	Yes No
Hemophilia	Yes No	Diabetes	Yes No
Hypertension/High Blood Pressure	Yes No	Seizures/Epilepsy	Yes No
Prolonged Bleeding/Transfusion	Yes No	Disabilities	Yes No
Anemia	Yes No	Asthma	Yes No
HIV/AIDS	Yes No	Arthritis	Yes No
Hepatitis	Yes No	Treated for Emotional Problems	Yes No
Tonsils/Adenoids Removed	Yes No	Ever Been Hospitalized	Yes No
If any of the above medical questions were answered "Yes," please explain:			

If Patient is Under 18			
Please list the name and birthdate of any siblings:			
Height:	Weight:	School:	Grade:
Father/Guardian 1 Name:		Mother/Guardian 2 Name:	
Has patient begun puberty?		Yes	No
If patient is a girl, has menstruation begun?		Yes	No
If patient is a boy, has his voice changed or does he have facial hair?		Yes	No
Has patient grown in the past year or has their shoe size changed recently?		Yes	No
Patient's interest in treatment?			
Has either biological parent ever had orthodontic treatment?		Yes	No

Orthodontic Insurance		
Is there orthodontic insurance that we can check for you? YES_____ NO_____		
Insurance Company Name:	Insurance Company Phone #	
Name of Insured	SSN:	DOB:

Signature: _____ Date: _____