

## Confidential Health History

Patient Biographical Information  First Name: Nickname: Nickname:											
First Name:	Midd	le Initial:	Last Name: Nickname: Social Security #:								
Birthdate:		Gender: Social Secu					rity #:				
Address:	•	С	ity:			;	Stat	te:	Zip:		
Main Phone: Cell F			Phone:					ail:			
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								No			
Middle Initial:   Last Name:   Nickname:   Nickname:   Social Security #:											
			<b>D</b> 1		•						
			Denta	ai H	istory						
Dentist Name:											
Check-up Frequency: Last Dental Visit:											
Ever had a previous orthodo	ntic co	nsult?	Yes	No		If so,	wh	en?			
What is your main orthodontion	c conc	ern?									
Speech problems/therapy?			s No		Brush teeth daily?					Yes	No
Grind or clench teeth?			s No		Floss teeth	Floss teeth daily?				Yes	No
Habits (thumb/finger, lip/nail biting)?			s No		Fluoride treatments?					Yes	No
Injury to face, jaw, teeth, or mouth?			Yes No Mouth breathing			g?			Yes	No	
Discomfort from teeth or gums?		Ye	s No		Snores during sleep?				Yes	No	
Pain, tenderness, or noise in either jaw?		jaw? Ye	Yes No Requires premedication?			ation?		Yes	No		
Frequent headaches?		Ye	s No		Any missin	g or e	extra	a teeth?		Yes	No
Neck/shoulder pain?			Yes No Apprehensive			sive al	about dental care?			Yes	No
Frequent sore throats? Yes No Frequently chews					/s g	um?		Yes	No		
If any of the above dental que	estions	were an	swere	d "Y	es," please o	explai	in:				
Medical History											
Physician Name:								Patient	Health	:	
Address:							Sta		_		
	is curre								_ '		

List any drug allergies or sensitivities that patient may have:

Insurance Company Name:  Name of Insured  SSN:  DOB:	Has patient ever had any of the fo	llowing	g cor	ndition	s? Ple	ease answer each res	spo	nse sep	arately.
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 Attack/Stroke Yes No Hormone Therapy Yes No Congenital Heart Defect Yes No Nervous Disorders Yes No Heart Murmur Yes No Bisphosphonate Therapy Yes No Heart Murmur Yes No Disabetes Yes No Hormone Therapy Yes No Heart Murmur Yes No Disabetes Yes No Hypertension/High Blood Pressure Yes No Disabilities Yes No Prolonged Bleeding/Transfusion Yes No Disabilities Yes No Anemia Yes No Disabilities Yes No Anemia Yes No Arthritis 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:    Fatient is Under 18	Rheumatic Fever	Yes	No	(	Cancer			Yes	No
Content   Cont	Tuberculosis/Lung Disease	Yes	No	ı	Family	History of Cancer		Yes	No
Kidney Disease Yes No Endocrine Problems Yes No Heart Attack/Stroke Yes No Hormone Therapy Yes No Heart Attack/Stroke Yes No Hormone Therapy 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 Hypertension/High Blood Pressure Yes No Diabetes Yes No Hypertension/High Blood Pressure Yes No Seizures/Epilepsy Yes No Hypertension/High Blood Pressure Yes No Disabilities Yes No Hilly/AIDS Yes No Asthma Yes No Anemia Yes No Arthritis Yes No Arthritis Yes No Hepatitis Yes No Arthritis 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:  ### Please list the name and birthdate of any siblings:  ### Has patient begun puberty? Yes No  ### If Patient is Under 18  ### Please list the name and birthdate of any siblings:  ### 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  ### Patient is a boy, has his voice changed or does he have facial hair? Yes No  ### Patient is interest in treatment?  ### Has either biological parent ever had orthodontic treatment? Yes No  ### Orthodontic Insurance  ### Insurance Company Phone #*  Name of Insurance Company Name:    Name of Insurance Company Phone #* Name of Insur	Pneumonia	Yes	No	ı	Receive	ed Radiation Treatme	nt	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 Disabetes Yes No Hypertension/High Blood Pressure Yes No Disabetes Yes No Hypertension/High Blood Pressure Yes No Disabilities Yes No Asthma Yes No Disabilities Yes No Hill/AlDS Yes No Disabilities Yes No Hepatitis Yes No Arthritis Yes No Horoidia Yes No Arthritis Yes No Horoidia 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	Liver Disease	Yes	No	(	Growth	Problems		Yes	No
Heart Disease Yes No Latex/Metal Allergy Yes No Congenital Heart Defect Yes No Nervous Disorders Yes No Herrous 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 Hypertension/High Blood Pressure Yes No Seizures/Epilepsy Yes No Prolonged Bleeding/Transfusion Yes No Disabilities Yes No Anemia Yes No Ashma Yes No HIV/AIDS Yes No Arthritis Yes No Hepatitis Yes No Treated for Emotional Problems Yes No Hopatitis 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	Kidney Disease	Yes	No	ı	Endocri	ine Problems		Yes	No
Congenital Heart Defect Yes No Nervous Disorders Yes No Heart Murmur Yes No Bisphosphonate Therapy Yes No Heart Murmur Yes No Diabetes 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 Anemia Yes No Asthma Yes No HIV/AIDS Yes No Arthritis Yes No Arthritis Yes No Hepatitis Yes No Arthritis Yes No Treated for Emotional Problems Yes No If any of the above medical questions were answered "Yes," please explain:    If Patient is Under 18	Heart Attack/Stroke	Yes	No	I	Hormor	ne Therapy		Yes	No
Heart Murmur  Yes No Bisphosphonate Therapy Yes No Hemophilia Yes No Diabetes Yes No Hypertension/High Blood Pressure Yes No Prolonged Bleeding/Transfusion Yes No Prolonged Bleeding/Transfusion Yes No Anemia Yes No HIV/AIDS Yes No Hepatitis Yes No Treated for Emotional Problems Yes No Tonsils/Adenoids Removed Yes No Treated for Emotional Problems Yes No If any of the above medical questions were answered "Yes," please explain:  ### Please list the name and birthdate of any siblings:  ### Height: ### Weight: ### School: ### Grade: ### Has patient begun puberty? ### Yes No If patient is a girl, has menstruation begun? ### 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? ### Has either biological parent ever had orthodontic treatment? ### Insurance Company Phone ### Name of Insurance  Insurance Company Phone # Name of Insured  ### Name of Insurance ### Name of Insurance #### Name of Insurance ### Name of Insurance #### Name of Insurance ##### Name of Insurance ##### Name of Insurance ###### Name of Insurance ####################################	Heart Disease	Yes	No	I	Latex/N	letal Allergy		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 Anemia Yes No Asthma Yes No HIV/AIDS Yes No Arthritis Yes No Hepatitis Yes No Arthritis 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	Congenital Heart Defect	Yes	No	ı	Nervou	s Disorders		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 Anemia Yes No Asthma Yes No Arthritis Yes No Arthritis Yes No Hepatitis Yes No Arthritis 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	Heart Murmur	Yes	No	i	Bisphos	sphonate Therapy		Yes	No
Prolonged Bleeding/Transfusion Yes No Disabilities Yes No Anemia Yes No Asthma Yes No Asthma 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	Hemophilia	Yes	No	ı	Diabete	es		Yes	No
Anemia Yes No Asthma Yes No Horitis Yes No Horitis Yes No Horitis Yes No Arthritis Yes No Horitis 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:    Fatient is Under 18	Hypertension/High Blood Pressure	Yes	No	,	Seizure	s/Epilepsy		Yes	No
HIV/AIDS Yes No Arthritis Yes No Hepatitis Yes No Treated for Emotional Problems Yes No Tonsits/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	Prolonged Bleeding/Transfusion	Yes	No	I	Disabili	ties		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	Anemia	Yes	No	,	Asthma	l		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? YESNO  Insurance Company Name: Insurance Company Phone #  Name of Insured SSN: DOB:	HIV/AIDS	Yes	No	1	Arthritis	3		Yes	No
If any of the above medical questions were answered "Yes," please explain:    If Patient is Under 18	Hepatitis	Yes	No	-	Treated	for Emotional Proble	ms	Yes	No
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?   Yes   No     The patient biological parent ever had orthodontic treatment?   Yes   No     Orthodontic Insurance     Insurance Company Name:   Insurance Company Phone #     Name of Insured   SSN:   DOB:	Tonsils/Adenoids Removed	Yes	No	ı	Ever Be	een Hospitalized		Yes	No
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:		If	Patie	ent is l	Jnder 1	18			
Father/Guardian 1 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?  YESNO  Insurance Company Name:  Name of Insured  SSN:  DOB:	Please list the name and birthdate o	f any si	bling	s:					
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?  Has patient grown in the past year or has their shoe size changed recently?  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?  Insurance Company Name:  Name of Insured  SSN:  DOB:	Height: Weight:	Weight: Sc			ol:		(	Grade:	
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Has either biological parent ever had orthodontic treatment?  Orthodontic Insurance  Is there orthodontic insurance that we can check for you?  Insurance Company Name:  Name of Insured  SSN:  DOB:	Has patient grown in the past year o	r has th	heir s	shoe siz	ze chan	nged recently? Ye	es	No	
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Is there orthodontic insurance that we can check for you?  Insurance Company Name:  Name of Insured  SSN:  DOB:	Has either biological parent ever had	d ortho	donti	c treatr	nent?	Ye	s	No	
Insurance Company Name:  Name of Insured  SSN:  DOB:		Or	thod	ontic I	nsuran	ice			
Name of Insured SSN: DOB:	Is there orthodontic insurance that we	e can c	heck	for you	ı?	YES	_ N	0	-
	Insurance Company Name:					Insurance Company	Pho	ne #	
Signature: Date:	Name of Insured				S	SN:		DOB	:
	Signature:				l	Date	<del></del>	I	