***Welcome**! At Henn Orthodontics, we care about your total health and appreciate your time in completing this confidential health history.*

Date: _____ Updated: _____

Patient Information

Patient's Name _____ I prefer to be called _____
Address _____ Gender _____ Age _____
Home Phone _____ Cell Phone _____ Birth date _____
Email Address _____ School _____ Grade _____
Hobbies/Interests/Pets _____
Siblings/Children? Names/Ages _____ _____ _____
Other Family Members in Treatment _____
Emergency Contact _____ Phone _____ Relationship _____
Whom may we thank for your referral? _____
What concerns you most about your teeth? _____

Custodial Parent/Guardian/Responsible Party (if patient is a minor/child)

Name _____ Relation to patient _____
Address _____
Email _____ Cell Phone _____ Carrier_____
Birth Date _____ SS #_____ Employer _____

Financial Information for Responsible Party (if different from above)

Name _____ Relation to patient _____
Address _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Social Security # _____ Birth date _____Years with current employer _____
Employer _____ Occupation _____

Orthodontic Insurance Information (please bring or email a copy of your card)

Insured's Name _____ Insured's Date of Birth _____
Insured's ID # _____ Insured's SS #_____ Insured's Cell # _____
Insured's Address _____
Insured's Employer _____
Insured's Employer Address _____
Insurance Company _____ Group # _____ Local # _____
Insurance Co. Address _____ Phone _____ Fax _____

Medical History

Physician _____ Date of last visit _____ Reason _____
Address _____ Phone _____

Please circle **Yes** or **No** (if Yes, please fill in details):

Yes No Do you have any food, drug, or other allergies? _____
Yes No Are you allergic to latex or nickel? _____
Yes No Are you taking any medications? _____
Yes No Are you presently or have you ever been a smoker? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you ever been hospitalized? _____
Yes No Do you require pre-medication prior to dental procedures? _____
Yes No Are you having any problems at work or in school? _____

Circle any of the following conditions you have presently or have had in the past:

Abnormal bleeding	Heart defect	Heart murmur	Pneumonia
Adenoids removed	Diabetes	Heart problems	Prolonged bleeding
Anemia	Dizziness	Hepatitis	Liver problems
Radiation/Chemo	Arthritis	Epilepsy	Herpes
Rheumatic fever	Asthma/Allergies	Fainting	High blood pressure
Tonsils removed	Bone disorders	Growth disorders	Nervous disorders
Tuberculosis	Other		

Any conditions not discussed that we should be aware of? _____

DENTAL HISTORY

Dentist Name _____ Date of last visit _____ Reason _____

Yes	No	Have you ever seen an orthodontist? If yes, who and when? _____
Yes	No	Do you have any snoring or grinding of the teeth?_____
Yes	No	Have you ever chipped or lost any teeth? _____
Yes	No	Have there been any injuries to the mouth, face, or teeth? _____
Yes	No	Do you have any missing permanent teeth? _____
Yes	No	Have you ever had a tooth extracted? _____
Yes	No	Do you have any difficulty chewing or swallowing? _____
Yes	No	Do you have any type of finger, thumb, or tongue habit? _____
Yes	No	Has anyone in your family received orthodontic treatment? _____
Yes	No	Do you ever experience any discomfort in your teeth or jaws? _____
Yes	No	Are you aware of any clicking or popping in your jaws? _____
Yes	No	Do you have any oral habits (ice chewing, nail biting, etc)? _____
Yes	No	Females only: Are you or might you be pregnant? _____

What is most important to you in seeking orthodontic care (circle all that apply)?

Low down payment	Low monthly payments	Advanced Technology	Clear/Invisible
Length of Treatment	Quality of Treatment	Comfort/Safety	Starting TX soon

Are there any other health, behavioral, or dental issues not discussed that we should be aware of?

_____

_____

"I have truthfully and completely answered all of the above questions and agree to inform this office of any changes. I consent to an orthodontic evaluation including photographs, radiographs, and examination."

Signature _____ Print name _____

Relationship to patient _____ Date _____ *Thank you!*

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