Patient Acquaintance and Health History

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Patient Name_____Age_____Date of Birth___/___/____Gender: _____
NICKNAME_____ If Adult: ☐ Married ☐ Single ☐ Divorced ☐ Widow
Residence_____
Street City/State/Zip
Home Phone #_____Cell Phone #_____E-mail_____
If applicable, what school does the patient attend? _____

PARENT/GUARDIAN/RESPONSIBLE PARTY (if different from above)

Name_____ Date of Birth___/___/____
Relationship to Patient:_____ Marital Status: ☐ M ☐ S ☐ D ☐ W
Residence_____Home #_____Cell #_____
Employer Name_____Occupation_____Work #_____

ADDITIONAL PARENT/GUARDIAN INFORMATION

Name_____ Date of Birth___/___/____
Relationship to Patient:_____ Marital Status: ☐ M ☐ S ☐ D ☐ W
Residence_____Home #_____Cell #_____
Employer Name_____Occupation_____Work #_____

PRIMARY DENTAL INSURANCE

Employer Name_____I.D. #_____
Insurance Company Name_____Group #_____
Ins. Co. Address_____
Ins. Co. Phone #_____ Effective Date_____
Policy Holder_____Gender_____Relationship to Patient_____
Policy Holder's SS#_____-_____-_____ Policy Holder's Date of Birth___/___/_____

SECONDARY DENTAL INSURANCE

Employer Name_____I.D. #_____
Insurance Company Name_____Group #_____
Ins. Co. Address_____
Ins. Co. Phone #_____ Effective Date_____
Policy Holder_____Gender_____Relationship to Patient_____
Policy Holder's SS# _____-_____-_____ Policy Holder's Date of Birth ___/___/_____

I certify that the above information is complete, accurate and current. I authorize the release of any medical information necessary to properly submit to my insurance company and request payment of benefits to Preston Orthodontics, PLLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.
I authorize the release of any photographs or radiographs taken regarding treatment for use in lectures/demonstration. I understand that both 2D and 3D radiographs are for the purpose of dental and orthodontic diagnosis and are in no way intended for medical diagnosis.

Signature (adult signature if patient is a minor)_____Date____/____/____

PATIENT DENTAL HISTORY

How did you hear about Preston Orthodontics?_____

☐ Dentist ☐ Friend ☐ Family member is a patient ☐ Internet

Date of your last dental examination_____General Dentist_____

Have you ever had an orthodontic consultation or treatment? ☐ Yes ☐ No Office_____

Any family members require/receive orthodontic treatment? ☐ Yes ☐ No Office_____

Please notify past/present history of:

_____Thumb/Finger Sucking	_____Jaw joint soreness	_____Clenching teeth
_____Tongue Thrusting	_____Jaw joint clicking	_____Grinding teeth
_____Mouth Breathing	_____Jaw joint popping	_____Muscle soreness (head and neck)
_____Lip Biting	_____Ringing in the ears	_____Frequent Headaches

PATIENT MEDICAL HISTORY

Present State of Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Physician_____

Do you have any general health problems or under a physician's care for an existing condition? ☐ Yes ☐ No

Please specify here:_____

Do you have a past or present history of taking any medications for Osteoporosis or other bone diseases (Bisphosphonates – ie: Fosamax, Actonel, Boniva, Reclast)? ☐ Yes ☐ No

Please list current drugs/medications_____

List any drug allergies/sensitivities_____

Please check those applicable if you have a history of:

☐ Rheumatic Fever ☐ Hepatitis ☐ HIV/AIDS ☐ Tuberculosis

☐ Jaundice ☐ Anemia ☐ Blood Disease ☐ Prolonged bleeding

☐ Diabetes ☐ Swollen ankles ☐ Bone Disease ☐ Prosthetic implants

☐ Convulsions ☐ Autism ☐ ADHD/ADD ☐ Psychiatric care ☐ Dental fear/anxiety

☐ Difficult chewing/swallowing ☐ Speech impediments ☐ Asthma/hay fever/allergies_____

☐ Repeated sore throats/colds ☐ Latex allergy ☐ Nickel allergy

☐ Heart Condition ☐ Pre-medication required = _____

History of visits to an ENT (Ear/Nose/Throat Dr) ENT Physician:_____

Tonsils removed?_____Date____/____/____ Adenoids removed?_____Date____/____/____

Is there anything else about you (or your child) that will help our treatment to be the best experience possible? _____

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