HEALTH HISTORY FORM

Date:_____

Patient's Last Name: _____ First Name:_____ Middle Initial: _____

Birth Date: _____ Age: _____ Sex: Male □ Female □ I Prefer To Be Called:_____

Home Phone #_____ Cell #_____ Work #_____

E-Mail Address: _____

Preference for Appointment Confirmation: E-Mail □ Cell □ Home □ Work □

Patient's Address_____
Street City State Zip

Custodial Parent(s) or Guardian(s): (If Applicable) _____

Person Financially Responsible For This Account: _____S.S.N. _____

Did your dentist recommend orthodontic treatment? Yes□ No□

Whom may we thank for recommending you to DVO for orthodontic treatment?_____

INSURANCE INFORMATION

Insurance Coverage for Orthodontic Treatment? Yes □ No □

Primary Policy Holder Name: _____ Employer:_____

Insurance Company Name and Address:_____

S.S.N./ID#_____ Birth Date: _____ Group #_____

Secondary Policy Holder Name: _____ Employer: _____

Insurance Company Name and Address:_____

S.S.N./ID#_____ Birth Date: _____ Group# _____

Attends School At: _____ Grade:_____

Other Family Members Treated Here: _____

Name of Patient's Dentist: _____ Town_____

Date Last Seen: _____ Reason: _____

Name of Patient's Physician(s): _____ Town_____

Date Last Seen: _____ Reason: _____

PATIENT PROFILE

Is the patient concerned with the appearance of the smile? _____

Why do you think orthodontic treatment is needed? _____

Are there any other family members with a similar condition? _____

Has there been any prior orthodontic treatment or appliances? _____

Is there any information that would help us better treat the patient? _____

MEDICAL HISTORY

Now or in the past, has the patient had:

YES	NO	DK/U	
□	□	□	Allergy to latex
□	□	□	Allergy to antibiotics? List_____
□	□	□	Allergy to any medications? List_____
□	□	□	Heart Disease or blood pressure issues? _____
□	□	□	Cancer, tumor, radiation or chemotherapy? _____
□	□	□	Arthritis? _____
□	□	□	Endocrine or thyroid problems? _____
□	□	□	Eating Disorder? _____
□	□	□	Environmental allergies, hayfever, asthma? _____

MEDICATIONS: List all medications, vitamins, supplements or herbal medications being taken and why:_____

_____

DENTAL HISTORY:

Have there been any accidents or trauma to the teeth or face? _____

Are there any teeth missing? _____

Have any teeth been removed? _____

Are there any other dental conditions or problems that we should be aware of? _____

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MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date: _____