

ADULT HEALTH HISTORY

PATIENT & RESPONSIBLE PARTY INFORMATION

Patient's name: _____ Sex: Male Female
Home address: _____
Mailing address: _____
How long at this address: _____ Home phone: _____ Work phone: _____
Previous address (if less than 3 years): _____
Social security number: _____ Birthdate: _____ Marital status: _____
Employer: _____ Occupation: _____ Number of years: _____
General dentist's name: _____ Dentist's phone: _____
How did you hear about our office? _____
Please list any family members treated in,our office: _____
Spouse's name: _____ Spouse's social security number: _____

DENTAL & ORTHODONTIC INSURANCE INFORMATION

Policy holder's name: _____ Policy holder's birthdate: _____
Insurance company: _____ Insurance company's phone: _____
Insurance company's address: _____
Group number: _____ Union local number: _____ Social security number: _____
Policy holder's employer: _____
Do you have dual coverage? Yes No (if yes, please complete below)
Policy holder's name: _____ Insurance company: _____
Insurance company's address: _____ Insurance company's phone: _____
Group number: _____ Union local number: _____ Social security number: _____
Policy holder's employer: _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature

Date

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Relationship: _____
Address: _____ Home phone: _____

MEDICAL & DENTAL HISTORY

Have you ever had one of the following medical conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney/Liver problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies to any drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy to latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral valve prolapse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy to nickel | <input type="checkbox"/> Yes <input type="checkbox"/> No Handicaps/Disabilities | <input type="checkbox"/> Yes <input type="checkbox"/> No Operation/Surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing impairment | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia/Blood disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthetic joints/Heart va |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular disease/Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic/Scarlet fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain from exertion | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic sinus problems | <input type="checkbox"/> Yes <input type="checkbox"/> No High/Low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Severe/Frequent headact |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions/Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsils/Adenoids remove |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital heart defect | <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital stays | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ | | |

Discuss any "yes" answers in the space provided: _____

Have you ever been told to take an antibiotic prior to dental visits? Yes No

Are you currently under the care of a physician for any medical conditions? Yes No

Discuss your current physical health: Good Fair Poor

Physician's name: _____

List any drugs/medications you are currently taking: _____

How frequently do you brush? _____ Floss? _____ Date of last dental visit: _____

Do you have any of the following dental habits?

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Clenching/Grinding teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Nail biting | <input type="checkbox"/> Yes <input type="checkbox"/> No Thumb/Lip sucking, biti |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No Tongue thrusting |

What would you like orthodontic treatment to address? _____

Have you ever been evaluated for or received orthodontic treatment? Yes No

Have you ever received an injury to the face, mouth, teeth or chin? Yes No

Have you been informed about any missing or extra permanent teeth? Yes No

Have you experienced pain, tenderness and/or clicking in the temporomandibular joint (TMJ)? Yes No

Have you ever had root canal therapy or any other type of dental treatment other than routine care? Yes No

Do you see a general dentist regularly for checkups? Yes No

Have you been told that you have periodontal (gum) disease? Yes No

Please make any other comments that you feel will be useful: _____

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

12780 Waterford Lakes Pkwy, Suite 130 Orlando, FL 32828

Phone: [407] 275.3330 Fax: [407] 275.3445

CHILD HEALTH HISTORY

PATIENT INFORMATION

Patient's name: _____ Sex: Male Female
Home address: _____
Home phone: _____ Social security number: _____ Birthdate: _____
School: _____ Grade: _____
Please list any hobbies, interests, sports or musical instruments played by your child: _____
Guardian's name (if child is a minor): _____ General dentist's name: _____
How did you hear about our office? _____
Please list any family members that have received treatment in our office: _____

RESPONSIBLE PARTY INFORMATION

Responsible party's name: _____ Sex: Male Female
Home address: _____
Mailing address: _____
How long at this address: _____ Home phone: _____ Work phone: _____
Previous address (if less than 3 years): _____
Social security number: _____ Birthdate: _____ Marital status: _____
Employer: _____ Occupation: _____ Number of years: _____
Spouse's name: _____ Spouse's social security number: _____
Spouse's birthdate: _____ Spouse's work phone: _____

DENTAL & ORTHODONTIC INSURANCE INFORMATION

Policy holder's name: _____ Policy holder's birthdate: _____
Insurance company: _____ Insurance company's phone: _____
Insurance company's address: _____
Group number: _____ Social security number: _____
Policy holder's employer: _____ Do you have dual coverage? Yes No (if yes, please complete below)
Policy holder's name: _____ Insurance company: _____
Insurance company's address: _____ Insurance company's phone: _____
Group number: _____ Social security number: _____
Policy holder's employer: _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature

Date

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Relationship: _____
Address: _____ Home phone: _____

MEDICAL & DENTAL HISTORY

Has your child ever had one of the following medical conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies to any drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney/Liver problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy to latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Mitral valve prolapse |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy to nickel | <input type="checkbox"/> Yes <input type="checkbox"/> No Handicaps/Disabilities | <input type="checkbox"/> Yes <input type="checkbox"/> No Operation/Surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing impairment | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic/Scarlet fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia/Blood disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Speech problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic sinus problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsils/Adenoids removed |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions/Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital heart defect | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital stays | |

Discuss any "yes" answers in the space provided: _____

Has your child ever been told to take an antibiotic prior to dental visits? Yes No

Is your child currently under the care of a physician for any medical conditions? Yes No

Discuss your child's current physical health: Good Fair Poor Has your child reached puberty? Yes No

Physician's name: _____ Physician's phone: _____

List any drugs/medications your child is currently taking: _____

How frequently does your child brush? _____ Floss? _____

Is your water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child see a general dentist regularly for checkups? Yes No Date of your child's last dental visit: _____

Does your child have any of the following dental habits?

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Clenching/Grinding teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Nail biting | <input type="checkbox"/> Yes <input type="checkbox"/> No Thumb/Lip sucking, biting |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No Mouth breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No Tongue thrusting |

What do you consider to be the main benefits of orthodontic correction for your child?

- Cosmetic Functional Psychological/Emotional Other: _____

What would you like orthodontic treatment to address? _____

Has your child ever been evaluated for or received orthodontic treatment? Yes No

Has your child ever received an injury to the face, mouth, teeth or chin? Yes No

Has your child been informed about any missing or extra permanent teeth? Yes No

Has your child experienced pain, tenderness and/or clicking in the temporomandibular joint (TMJ)? Yes No

Is your child self-conscious about his/her teeth? Yes No

Discuss any "yes" answers in the space provided: _____

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

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