

Patient History

Date _____

Patient's Name _____

Address _____
Last First Middle Initial Nick Name

Street City Zip

Home Phone _____ Date of Birth _____ Email (for appt. reminders) _____

If patient is a minor, give parent or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____

Last First Middle

Residence _____

Street City Zip

Mailing Address _____

(If different) Street City Zip

How long at this address? _____ Home Phone _____ Cell Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of year's employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of year's employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual insurance? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No. _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____

Street City Zip

Phone Nos. _____

Home Work Cell

Signature (Parent's signature if minor) _____

Patient's Name: _____

Medical History

Physician _____ Date of last visit _____

Address _____ Phone No. _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any major operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have you ever taken a bisphosphonate medication? (i.e. Fosamax, etc.) _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | | |
|------------------------------|-----------------|--------------------------|----------------------------|--------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia | Anemia |
| Dizziness | Herpes | Prolonged Bleeding | Arthritis | Epilepsy |
| High Blood Pressure | Asthma/Hayfever | Radiation/Chemotherapy | Gastrointestinal Disorders | HIV/Aids |
| Rheumatic Fever | Bone Disorders | Heart Problems | Kidney Problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer | |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
 - Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
 - Yes No Have you ever lost or chipped any teeth? _____
 - Yes No Have there been any injuries to face, mouth or teeth? _____
 - Yes No Is any part of your mouth sensitive to temperature or pressure? _____
 - Yes No Do your gums bleed when you brush? _____
 - Yes No Do you have any type of thumb or tongue habit? _____
 - Yes No Are you a mouth breather? _____
 - Yes No Have you ever seen an orthodontist? If yes, who and when? _____
 - Yes No Has anyone in your family received orthodontic treatment? _____
 - Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
 - Yes No Are you aware of your jaw clicking or popping? _____
 - Yes No Are you aware of clenching your teeth during the day? _____
 - Yes No Have you ever been told that you grind your teeth? _____
 - Yes No Do you have "tension" headaches? _____
 - Yes No Have you ever experienced chronic ringing in your ears? _____
 - Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
 - Yes No Are you aware that some appointments will be during school/work hours? _____
- Please list some hobbies or interests _____

Female Patients Only:

- Yes No Are you pregnant? _____
- Yes No If under age 15, has menstruation started? If so, at what age? _____

I understand that my diagnostic records (photos/x-rays) may be used for educational and/or promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Drs. Paul and Aurelia Bonham to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

(Parent or Guardian if patient is a minor)

Updates (date & initial) _____