Patient History

Date_____

Patient's Name_____
Last First Middle Initial Nick Name

Address_____
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? _____

SCHOOL _____

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 #_____Birth Date _____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 #_____Birth Date _____Work Phone _____Cell Phone_____

Dental Insurance Information

Insured's Name_____ Insured's Social Security #_____

Insurance Co. _____Group #_____Subscriber #_____

Insurance Co. Address _____Phone #_____

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

Insured's Name_____ Insured's Social Security #_____

Insurance Co. _____Group #_____Subscriber #_____

Insurance Co. Address _____Phone #_____

Emergency Information

Name of nearest relative not living with you_____

Complete address_____
Street City Zip

Phone #'s _____
Home Work Cell

Signature (Parent's signature if minor) _____

Patient's Name: _____

Medical History

Physician_____Date of last visit_____

Address_____Phone #_____

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.)_____
Yes No Are you allergic to Latex?_____

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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 permanent 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) _____