

JENKINS ORTHODONTICS

Health History Form



1. PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) () _____

(Work) () _____

Adult Patient

Birthdate ____ / ____ / ____ Age: _____

Social Security #: _____

Employer: _____

Employer Address: _____

Occupation/Position: _____

How long there? _____

Where and when are the best times to reach you?

Child Patient

Birthdate ____ / ____ / ____ Age: _____

School : _____ Grade: _____

Sports: _____

Hobbies: _____

Musical Instruments: _____

2. BILLING INFORMATION

Person(s) responsible for paying this account:

Billing Address: _____

Phone Number(s): _____

Person(s) responsible for making appointments:

Phone: _____

Whom may we thank for referring you?

Other family members seen by us:

3. PARENT OR SPOUSE INFORMATION

Marital Status: Married Widowed Divorced
 Single Separated

Child Patient Lives With:

Both Parents Mom Dad

Other: _____

Mom's Name (or Spouse): _____

Social Security #: _____

Employer: _____

Employer Address: _____

Work phone: () _____

Dad's Name (or Spouse): _____

Social Security #: _____

Employer: _____

Employer Address: _____

Work phone: () _____

4. ORTHODONTIC INSURANCE:

Insurance Company Name: _____

Address: _____

Phone: () _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship To Patient: _____

Insured's Date of Birth: _____ / _____ / _____

Insured's Employer: _____

5. MEDICAL HISTORY

Patient's Physician: _____

Physician's Address: _____

Physician's Phone: () _____

Please describe patient's physical health:

Excellent Good Fair Poor

Please list all medications and other items patient is **allergic** to:

None _____

Please list all medications patient is taking and reasons:

Has patient ever had any of the following medical problems?

Y N Allergic to plastic	Y N Allergic to Latex/Metals
Y N Heart Murmur	Y N Congenital Heart Defect
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheumatic Fever	Y N Hearing Impairment
Y N HIV+/AIDS	Y N Any Operations
Y N Hemophilia	Y N Any Stays in a Hospital
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Handicaps/Disabilities
Y N Tuberculosis	Y N Allergies to any Drugs

Please explain above answers or mention any other medical problems that patient has:

6. DENTAL HISTORY

Patient's Dentist: _____

Dentist's Address: _____

Dentist's Phone: () _____

What are your main orthodontic concerns?

Has patient ever been evaluated or had orthodontic treatment before? Yes No

Have there ever been any injuries to the face, mouth, teeth or chin? Yes No

Have adenoids or tonsils been removed? Yes No

Has patient ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Has patient ever had any of the following dental problems?

Y N Mouth breather
Y N Lip sucking/biting
Y N Speech problems
Y N Clenching/grinding teeth
Y N Nail biting
Y N Nursing bottle habits
Y N Tongue thrust
Y N Jaw cysts, abscess, infections
Y N Dead teeth, root canal treatment
Y N Bleeding gums
Y N Mouth odor, bad taste
Y N Gingivitis, periodontal problems
Y N Food impaction between teeth
Y N Gum boils, canker sores, cold sores
Y N Lip, cheek, tongue biting
Y N Thumb, finger, tongue sucking habits
Y N Abnormal swallowing habit
Y N Jaw clicking, popping, pain
Y N Difficulty in chewing or breathing
Y N Missing or extra teeth
Y N Loose, broken or missing fillings
Y N Any teeth irritating lip, tongue
Y N Concern about spaced, crowded, protruding teeth
Y N Concern about under- or overdeveloped jaw
Y N Relative with similar tooth or jaw relationship
Y N Wisdom teeth problems

The information that I have given is correct to the best of my knowledge, and I understand that it will be held in the strictest confidence. I understand that it is my responsibility to inform this office of any changes in the patient's medical status. I also authorize the dental staff to perform the necessary dental services.

Signature

Today's Date: _____