Sandifer ORTHODONTICS

A B C

Health History Form

Patient's Name:_____ Age:_____ Birthdate:_____

Name you like to be called:_____ Hm Phone:_____ School:_____ Grade: _____

Address:_____ City:_____ State:_____ Zip:_____

Social Security #:_____ Do you play a musical instrument? ☐Yes ☐No

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

RESPONSIBLE PARTY

Name: _____ Marital Status:_____

Address:_____ City:_____ State:_____ Zip:_____

Mailing Address *(if different)*:_____ City:_____ State:_____ Zip:_____

How long at this address?_____

Previous Address:_____ City:_____ State:_____ Zip:_____

Social Security #: _____ Birthdate:_____ Relationship to Patient: _____

Employer: _____ Occupation:_____ No. of years employed: _____

Social Security #: _____ Birthdate:_____ Work: _____

INSURANCE INFORMATION

Insured Name: _____ Insured's SS#:_____ Insurance Co:_____

Insurance Co. Address:_____ Group #:_____

Phone:_____ Insured's Employer:_____

Do you have dual coverage? ☐Yes ☐No If yes:_____

Insured's Name: _____ Insured's SS#:_____ Insured's Employer:_____

Ins.Co. Address:_____ Group #:_____ Phone: _____

Phone:_____ Insured's Employer:_____

Insurance Co. Address:_____

MEDICAL/DENTAL HISTORY

Physician's Name:_____ Phone: _____

Dentists Name: _____ Phone: _____

☐Yes ☐No Are you currently under any medical treatment?_____

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?_____

☐Yes ☐No Are you aware of either clenching or grinding of teeth?_____

☐Yes ☐No Do you have frequent headaches? How often?_____

☐Yes ☐No Do you have ear problems? (Aches, ringing, dizziness, fullness)_____

☐Yes ☐No Do you have difficulty breathing through the nose?_____

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?_____

☐Yes ☐No Do you have speech problems, or are you in speech therapy?_____

☐Yes ☐No Have you had your tonsils and/or adenoids removed?_____

☐Yes ☐No Has there been any history of: ☐Joint swelling ☐Asthma ☐TB ☐Aids ☐Kidney ☐Liver Condition ☐Epilepsy ☐Rheumatic fever ☐Other major illnesses?_____

☐Yes ☐No Do you bleed easily?_____

☐Yes ☐No Is there a tendency to faint or become dizzy?_____

☐Yes ☐No Do you have allergies? (Sulphur, penicillin, novocaine, etc.)_____

☐Yes ☐No Are you currently taking any medication? List:_____

☐Yes ☐No Do you have a heart condition? ☐Yes ☐No Do you pre-medicate? ☐Yes ☐No Cardiologist:_____

☐Yes ☐No Do you have sleep apnea?_____

☐Yes ☐No Do you smoke or chew tobacco?_____

☐Yes ☐No Have there been any injuries to the teeth?_____

☐Yes ☐No Have you had any permanent teeth extracted?_____

☐Yes ☐No Have we treated any other family members? ☐Yes ☐No Who:_____

☐Yes ☐No Is there a possibility that you may be pregnant? If so, please alert us as we will not gather any x-rays.

Signature:_____ Date:_____

Date:_____ Patient's Name:_____ Age:_____