Sterling ORTHODONTICS

# PATIENT HEALTH HISTORY

Please fill out this form and bring it with you to your next appointment. We look forward to meeting you.

## PART I: PATIENT INFORMATION

First Name _____ Preferred Name _____ Middle _____ Last Name _____

Address _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____

Birth Date _____ Age _____ Hobbies/Interests _____

School/Grade _____ Dentist _____ Physician _____

Primary Person Responsible _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____ Employer _____

Dental Insurance Company _____ Flexible Spending Account ☐ Yes ☐ No

Group # _____ Insurance ID # _____ S.S. # _____

Secondary Person Responsible _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____ Employer _____

Dental Insurance Company _____ Flexible Spending Account ☐ Yes ☐ No

Group # _____ Insurance ID # _____ S.S. # _____

## PART II: PATIENT DENTAL HISTORY

Do you have, or have you had, any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Missing, Extracted, or Extra Teeth | ☐ Yes | ☐ No | Grinding/Clenching Teeth | ☐ Yes | ☐ No |
| Trouble Chewing | ☐ Yes | ☐ No | Clicking, Popping, or Jaw Joint Pain/TMJ | ☐ Yes | ☐ No |
| Sensitive Teeth | ☐ Yes | ☐ No | Facial Injuries or Trauma | ☐ Yes | ☐ No |
| Bleeding Gums | ☐ Yes | ☐ No | Periodontal (Gum) Problems | ☐ Yes | ☐ No |
| Root Canals, Crowns, or Bridges | ☐ Yes | ☐ No | Under/Over Developed Jaws | ☐ Yes | ☐ No |
| Thumb/Finger Sucking | ☐ Yes | ☐ No | Frequent Cold Sores | ☐ Yes | ☐ No |

If yes, please explain _____

Do you have a dental cleaning and exam every six months? ☐ Yes ☐ No Date of Last Exam _____

## PART III: PATIENT MEDICAL HISTORY

Have you been treated by a physician for any condition in the last two years? _____

Do you now have any, or have you ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| HIV/AIDS | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No |
| Allergies | ☐ Yes | ☐ No | Heart Murmur | ☐ Yes | ☐ No |
| Anemia, Blood/Bleeding Problems | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No |
| Arthritis, Bone/Muscle Problems | ☐ Yes | ☐ No | Immune System Problems | ☐ Yes | ☐ No |
| Asthma or Breathing Difficulties | ☐ Yes | ☐ No | Operations | ☐ Yes | ☐ No |
| Birth Defects | ☐ Yes | ☐ No | Seizure Disorder | ☐ Yes | ☐ No |
| Circulation/Blood Pressure Problems | ☐ Yes | ☐ No | Stomach, Liver, or Kidney Problems | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Substance Abuse Problem | ☐ Yes | ☐ No |
| Eating Disorders | ☐ Yes | ☐ No | Taking a Bisphosphonate Medication | ☐ Yes | ☐ No |
| Endocrine Problems | ☐ Yes | ☐ No | Tonsil or Adenoid Problems | ☐ Yes | ☐ No |
| Fainting/Dizziness | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Headaches or Earaches | ☐ Yes | ☐ No | Tumors, Cysts, or Cancer | ☐ Yes | ☐ No |

If yes, please explain _____

Please list any medications taken _____

Do you need to be pre-medicated with an antibiotic before an invasive dental procedure? _____

Do you regularly take Advil, Aleve, aspirin or other anti-inflammatory products? _____

Do you drink carbonated beverages (soda) on a daily basis? ☐ Yes ☐ No If yes, how many? _____

Are you a regular user of tobacco products such as cigarettes or smokeless tobacco, etc? ☐ Yes ☐ No

Female patients: To the best of your knowledge, are you pregnant? ☐ Yes ☐ No

Girls only: Has the patient started her monthly periods? ☐ Yes ☐ No If so, approximately when? _____

Please provide any additional information that may be helpful in the diagnosis and treatment of your condition.

_____

## PART IV: OTHER INFORMATION

How did you hear about our office? _____

Why did you choose us? _____

Have you had any other orthodontic consultations or treatment? _____

Have any family members ever had orthodontic treatment? _____

*Sterling Orthodontics has my permission to obtain diagnostic materials deemed necessary for orthodontic evaluation. I also authorize Sterling Orthodontics to provide other health care providers with information regarding my/my child's orthodontic care, if considered appropriate. I also understand it is my responsibility to keep Sterling Orthodontics informed of any change in medical or dental health status and that, when appropriate, a credit bureau report may be obtained.*

_____ _____ _____ _____

Parent/Patient's Signature Date Signature of Orthodontist Date