MARSTON ORTHODONTICS

Member American Association of Orthodontists

New Patient Health History

Patient Biographical Information			
Please indicate whether the patient is an: Adult or Minor			
First Name		Birth date	
Middle Initial		Gender	
Last Name		Main Phone	
Nickname		2nd / Cell Phone	
Address		Email	
Address		Social Security	
City			
State			
Zip			
Any sports, hobbies or musical instruments?			
Who can we thank for referring you to our office?			

Responsible Party Information (if patient is a minor)			
First Name:		Address:	
Middle Initial		City:	
Last Name:		State:	
Marital Status:		Zip	
Main Phone:		SS#	
Cell Phone:		Work Phone #:	
E-mail:		Relationship to Patient	
Additional Responsible Party Information (if applicable)			
First Name		Address:	
Middle Initial		City:	
Last Name		State:	
Marital Status:		Zip	
Main Phone:		SS#	
Cell Phone:		Work Phone:	
E-mail:		Relationship to Patient	

Dental Insurance			
Subscriber Name:		Insurance Company:	
Relationship to patient:		Employer:	
Subscriber Birthdate:		Subscriber ID or SS#:	
Does your insurance cover orthodontics?		Group #:	
Secondary Dental Insurance			
Do you have dual insurance? (If yes, complete the following)			
Subscriber Name:		Insurance Company:	
Relationship to patient:		Employer:	
Subscriber Birthdate:		Subscriber ID or SS#:	
Does your insurance cover orthodontics?		Group #:	

MARSTON ORTHODONTICS

Member American Association of Orthodontists

Dental History

Dentist Name:			
Dentist Checkup Frequency:		Last Dental Visit:	
Has patient had a consult for orthodontic treatment previously?		If so, when?	
Main orthodontic concern(s):			

Please answer all of the following:

	yes	no		yes	no
Speech problems/therapy			Brush teeth daily		
Grind or clench teeth			Floss teeth daily		
Oral habits			Fluoride treatment		
Injury to face, jaw, teeth or mouth			Mouth breathing		
Discomfort from teeth or gums			Snores during sleep		
Pain, tenderness or noise in either jaw			Requires premedication		
Frequent headaches			Any missing or extra permanent teeth		
Neck/shoulder pain			Apprehensive about dental care		
Frequent sore throats			Frequently chew gum		
Autism or Autism Spectrum Disorder			ADHD		

Explain a “Yes” (if needed)

Medical History

Physician Name:			
Address		Date of last physical	
City		Patient Health:	
State		Current medications	
Zip		Drug allergies or sensitivities	

Please answer all of the following:

	yes	no		yes	no
Rheumatic Fever			Cancer		
Tuberculosis/Lung Disease			Family History of Cancer		
Pneumonia			Received Radiation Treatment		
Liver Disease			Growth Problems		
Kidney Disease			Endocrine Problems		
Heart Attack/Stroke			Hormone Therapy		
Heart Disease			Latex/Metal Allergy		
Congenital Heart Defect			Nervous Disorders		
Heart Murmur			Bone Disorders/Bone Loss		
Hemophilia			Diabetes		
Hypertension/High Blood Pressure			Seizures/Epilepsy		
Prolonged Bleeding/Transfusion			Handicaps/Disabilities		
Anemia			Asthma		
HIV/AIDS			Arthritis		
Hepatitis			Treated for Emotional Problems		
Tonsils/Adenoids Removed			Ever Been Hospitalized		

Is there any other health related condition or concern that you think we should know about?

MARSTON ORTHODONTICS

Member American Association of Orthodontists

Patients Under 18			
Height:		School:	
Weight:		Grade:	
Father/Guardian 1 Name			
Mother/Guardian 2 Name			
Has patient begun puberty?			
If a girl, has menstruation begun			
If boy, has voice changed or have facial hair?			
Has the patient grown in the past year or has their shoe size changed recently?			
Patient's interest in treatment?			
Has either biological parent ever had orthodontic treatment?			

Printed name of person completing the form

Date

Signature

Relationship to patient if a minor