MARSTON ORTHODONTICS

Member American Association of Orthodontists

New Patient Health History

Patient Biographical Information	
Please indicate whether the patient is an adult or a minor:	
First Name	Birth date
Middle Initial	Gender
Last Name	
Nickname	
Address	Main Phone
City	2nd / Cell Phone
State	Email
Zip	Social Security
Family or Friends seen	
Sports, Hobbies or Music instrument	
Who referred you	
If minor, which school does the patient attend?	

Responsible Party Information			
First Name:		Address:	
Middle Initial		City:	
Last Name:		State:	
Marital Status:		Zip	
Main Phone:		Social Security Number	
Cell Phone:		Work Phone #:	
E-mail:			
Relationship to Patient			
Additional Responsible Party Information (if applicable)			
Second RP Name		Address:	
Second RP Initial		City:	
Second RP Last Name		State:	
Marital Status:		Zip	
Main Phone:		Social Security Number:	
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#:	
		Group #:	
Does your insurance cover orthodontics?			
Do you have dual insurance?			
If yes, complete the following			
Subscriber Name:		Insurance Company:	
Relationship to patient:		Employer:	
Subscriber Birthdate:		Subscriber ID or SS#:	
		Group Number:	
Does your insurance cover orthodontics?			

9330 Carmel Mountain Road, Suite D San Diego, CA 92129
P: (858) 484-6100 F: (858) 484-8601
info@marstonorthodontics.com www.marstonorthodontics.com

MARSTON ORTHODONTICS

Member American Association of Orthodontists

Dental History			
Dentist Name:			
Dentist Checkup Frequency:		Last Dental Visit:	
Has patient had a consult or treatment:		If so, when?	
Main orthodontic concern:			
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 any "Yes"			

Medical History			
Physician Name:			
Address		Date of last physical	
City		Patient Health:	
State		Current medications	
Zip		Drug allergies or sensitivities	
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 condition or problem that you think we should know about?			

Patients Under 18			
Siblings			
Height:		School:	
Weight:		Grade:	
Father/Guardian 1 Name		Mother/Guardian 2 Name	
Has patient begun puberty			
If girl, has menstruation begun			
If boy, has voice changed or have facial hair			

9330 Carmel Mountain Road, Suite D San Diego, CA 92129
P: (858) 484-6100 F: (858) 484-8601
info@marstonorthodontics.com www.marstonorthodontics.com

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?

Date Submitted

_____ _____

Type name of Patient/Responsible Party Date

Blake Marston, DDS _December 6, 2018__

Date

9330 Carmel Mountain Road, Suite D San Diego, CA 92129
P: (858) 484-6100 F: (858) 484-8601
info@marstonorthodontics.com www.marstonorthodontics.com