**HEALTH HISTORY / PATIENT INFORMATION FOR ERICKSON ORTHODONTICS**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male\_\_\_\_\_\_\_\_\_\_\_\_\_ Female\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main concern for orthodontic treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Cleaning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parental Information**

If a Minor:

Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stepfather’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stepmother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary DENTAL Insurance Information**

Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID/ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE SECONDARY COVERAGE \_\_\_\_\_No \_\_ Yes (If yes, please include information on bottom of page 2)

**Please circle Y for Yes or N for No**

Y N Permanent or “extra” teeth removed? Y N Abnormal swallowing habit? (tongue thrusting)

Y N History of speech problems? Y N Any pain in jaw or ringing in ears?

Y N Mouth breathing habit, snoring, difficulty breathing? Y N Dead teeth or root canals treated?

Y N Teeth sensitive to hot or cold; teeth throb or ache? Y N Aware of loose, broken or missing fillings?

Y N Bleeding gums, bad taste, or mouth odor? Y N Jaw fractures, cysts, or mouth infections?

Y N Difficulty when chewing or jaw opening? Y N Frequent canker sores or cold sores?

Y N Food impaction between teeth? Y N Concerned about spaced/crooked/protruding teeth?

Y N Tooth grinding or jaw clenching? Y N Any teeth irritating cheek, lip, tongue, or palate?

Y N Aware of under or over developed lower jaw? Y N Any pain or soreness in the muscles of the face or around the ears?

Y N Taking any forms of fluoride? Y N Any relatives with similar tooth or jaw relationships?

Y N Had periodontal (gum) treatment? Y N Any serious problems w/previous dental treatment?

Y N Ever had a prior orthodontic exam or treatment? Y N Would you object to wearing braces if recommended?

Y N Are you taking Bisphosphonates or Fosamax?

Y N Are you taking any medications? If so, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Birth defects or hereditary problems? Y N Skin disorder?

Y N Bone fractures, or major accidents? Y N Easily tired?

Y N Endocrine or thyroid problems? Y N Chest pain, shortness of breath, ankle swelling?

Y N Kidney problems? Y N Tonsil or adenoid condition?

Y N Diabetes? Y N Frequent headaches, colds, or sore throats?

Y N Cancer, tumor, radiation treatment or chemo? Y N Ear, nose & throat condition?

Y N Stomach ulcer or hyperactivity? Y N Hay fever, asthma, sinus trouble or hives?

Y N Polio, mononucleosis, Tuberculosis, Pneumonia? Y N Does the patient eat a well-balanced diet?

Y N Problems of the immune system? **ALLERGIES OR REACTION TO ANY OF THE FOLLOWING:**

Y N AIDS or HIV positive? Y N Foods? (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Hepatitis, jaundice, or liver problems? Y N Medications? (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Loss of weight recently, poor appetite? Y N Acrylic?

Y N High or low blood pressure? Y N Ibuprofen, Motrin, Advil, Aspirin?

Y N Mental health disturbance or depression? Y N Vinyl?

Y N Vision, hearing, tasting or speech difficulties? Y N Local anesthesia? (Novocain, Lidocaine)

Y N History of eating disorder (anorexia, bulimia)? Y N Penicillin or other antibiotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Excessive bleeding, anemia, or bleeding disorder? Y N Codeine or other narcotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y N Restless sleeper? (child) Y N Metals? (jewelry, clothing snaps)

Y N Snoring? (child) Y N Loud breathing when asleep? (child)

Y N Nasal congestion? (child) Y N Breathes mostly through mouth? (child)

Y N Hyperactive or Inattentive? (child) Y N Excessively sleepy? (child)

Y N Fainting spells, seizures, Epilepsy, or neurological problems? Y N Breathing is paused during sleep? (child)

Y N Cardiovascular problems (heart trouble, heart attack, angina, coronary heart defects, heart murmur or rheumatic heart disease)?

Y N Are there any other concerns or special needs we should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALES ONLY**: Y N Pregnant Y N Taking birth control Y N Nursing

I have read and understand the above questions. I will not hold my orthodontist or any member of his or her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to my medical/dental history or status, I will so inform this practice.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_