



**ORTHODONTIC  
HEALTH HISTORY FORM**

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

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  I Prefer To Be Called: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Preference for Appointment Confirmation: E-Mail  Cell  Home  Work

Patient's Address \_\_\_\_\_  
Street City State Zip

Attends School At: \_\_\_\_\_ Grade: \_\_\_\_\_

Other Family Members Treated Here: \_\_\_\_\_

Custodial Parent(s) or Guardian(s): (If Applicable) \_\_\_\_\_

Name of Patient's Dentist: \_\_\_\_\_ Town \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

Name of Patient's Physician(s): \_\_\_\_\_ Town \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

Person Financially Responsible For This Account: \_\_\_\_\_

Insurance Coverage for Orthodontic Treatment? Yes  No

Primary Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

S.S.N./ID# \_\_\_\_\_ Birth Date: \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Policy Holder Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company Name and Address: \_\_\_\_\_

S.S.N./ID# \_\_\_\_\_ Birth Date: \_\_\_\_\_ Group# \_\_\_\_\_

Did your dentist recommend orthodontic treatment? Yes  No

Who may we thank for recommending you to Kidzdent for orthodontic treatment? \_\_\_\_\_

**PATIENT PROFILE**

Is the patient concerned with the appearance of the smile? \_\_\_\_\_

Why do you think orthodontic treatment is needed? \_\_\_\_\_

Are there any other family members with a similar condition? \_\_\_\_\_

Has there been any prior orthodontic treatment or appliances? \_\_\_\_\_

Is there any information that would help us better treat the patient? \_\_\_\_\_

**MEDICAL HISTORY**

Now or in the past, has the patient had:

**YES**   **NO**   **DK/U**

        Allergy to latex

        Allergy to antibiotics? List \_\_\_\_\_

        Allergy to any medications? List \_\_\_\_\_

        Heart Disease or blood pressure issues? \_\_\_\_\_

        Cancer, tumor, radiation or chemotherapy? \_\_\_\_\_

        Arthritis? \_\_\_\_\_

        Endocrine or thyroid problems? \_\_\_\_\_

        Eating Disorder? \_\_\_\_\_

        Environmental allergies, hayfever, asthma? \_\_\_\_\_

**MEDICATIONS:** List all medications, vitamins, supplements or herbal medications being taken and why: \_\_\_\_\_

**DENTAL HISTORY:**

Have there been any accidents or trauma to the teeth or face? \_\_\_\_\_

Are there any teeth missing? \_\_\_\_\_

Have any teeth been removed? \_\_\_\_\_

Are there any other dental conditions or problems that we should be aware of? \_\_\_\_\_

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**MEDICAL HISTORY UPDATE OR CHANGES**

Comments: \_\_\_\_\_

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

**MEDICAL HISTORY UPDATE OR CHANGES**

Comments: \_\_\_\_\_

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