# PRESCOTT ORTHODONTICS
# PRESCOTT VALLEY ORTHODONTICS

## Welcome to our office

Administrative and Health History Form

Date________________

### Patient Information

Patient's Name____________________________________________ Sex ________
(Last / First / Middle / Nickname)

Address Rent/Own ____________________________________________
(Street / City / State / Zip)

Home Phone________________ Birthdate________________ Age______ Social Security# ________________

Family Dentist________________ Physician________________ School________________ Grade ______

Patient's Interests or hobbies ____________________________________________

If patient is a minor, give parent's or guardian's name ____________________________________________

Names and ages of other children in family____________________________________________

Whom may we thank for referring you to our office? ____________________________________________

Email Address ____________________________________________

### Responsible Party Information

Name____________________________________________
(Last / First / Middle / Marital Status)

Residence ____________________________________________
(Street / City / State / Zip)

Mailing Address ____________________________________________
(Street / City / State / Zip)

How long at this address__________ Rent/Own Cell Phone ________________ Work Phone ________________

Previous Address (if less than 3 yrs.)____________________________________________
(Street / City / State / Zip)

Social Security#________________ Birthdate________________ Relationship to patient ________________

Employer________________ Occupation________________ No. Years Employed________

Spouse's Name________________________________ Relationship to Patient ________________
(Last / First / Middle)

Employer________________ Occupation________________ No. Years Employed ________

Social Security#________________ Birthdate________________ Work Phone ________________

Responsible Party Email Address (es) ____________________________________________

### Orthodontic Insurance Information

Insured's Name________________________________ Insured's Soc. Sec. # ________________

Insurance Company________________________ Group No.________________ Phone No.________________

Insurance Co. Address ____________________________________________

Do you have dual coverage? Yes No If yes:

Insured's Name________________________________ Insured's Soc. Sec.#________________

Insurance Company________________________ Group No.________________ Phone No.________________

Insurance Co. Address ____________________________________________

### Emergency Information

Name of nearest relative not living with you ____________________________________________

Complete Address ____________________________________________

Phone________________________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ____________________________________________

Updates (date & initial) ____________________________________________

## Medical History

**Has Patient had any of the following:**

| | Yes | No |
|---|---|---|
| Aids (or tested HIV positive) | ❑ | ❑ |
| Cancer | ❑ | ❑ |
| Tobacco Use | ❑ | ❑ |
| Ulcers | ❑ | ❑ |
| Asthma | ❑ | ❑ |
| Anemia | ❑ | ❑ |
| Diabetes | ❑ | ❑ |
| Fainting | ❑ | ❑ |
| Nervous Problems | ❑ | ❑ |
| Hepatitis | ❑ | ❑ |
| Rheumatic Fever | ❑ | ❑ |
| Glaucoma | ❑ | ❑ |
| Convulsions | ❑ | ❑ |
| Kidney Problems | ❑ | ❑ |
| Endocrine or Thyroid Problems | ❑ | ❑ |
| Bone Disorders | ❑ | ❑ |
| Prolonged Bleeding | ❑ | ❑ |
| Liver Problems | ❑ | ❑ |
| Allergies | ❑ | ❑ |
| Removal of Tonsils & Adenoids | ❑ | ❑ |
| Frequent Headaches | ❑ | ❑ |
| Heart Murmur/Premed | ❑ | ❑ |
| Mitral Valve Prolapse | ❑ | ❑ |

| | Yes | No |
|---|---|---|
| **Patient is in good health** | ❑ | ❑ |
| **Patient is under physician's care** | ❑ | ❑ |

**If so, for what reason** ____________________

____________________

| | Yes | No |
|---|---|---|
| **Are there any impending medical conditions** | ❑ | ❑ |

**If so, describe** ____________________

____________________

| | Yes | No |
|---|---|---|
| **Patient is taking prescription medications** | ❑ | ❑ |

**If so, list** ____________________

____________________

**Patient's height**__________ **weight**__________

**For females only;**

| | Yes | No |
|---|---|---|
| **Is the patient presently pregnant** | ❑ | ❑ |
| **Does the patient take birth control pills** | ❑ | ❑ |

**For children and adolescence only:**

| | Yes | No |
|---|---|---|
| **Has puberty been reached (start of menstruation or voice change)** | ❑ | ❑ |

**If so, and within the last two years. when?** __________

| | Yes | No |
|---|---|---|
| **Does patient require pre-medication or antibiotics before dental appointments** | ❑ | ❑ |

## Dental History

| | Yes | No | |
|---|---|---|---|
| Patient has had a recent dental check-up | ❑ | ❑ | Date __________ (For office use only) |
| Any missing or extra permanent teeth | ❑ | ❑ | |
| Blow or injury to face or teeth | ❑ | ❑ | __________ |
| Night time teeth clenching or grinding habit | ❑ | ❑ | __________ |
| Speech problem | ❑ | ❑ | __________ |
| Clicking or pain when opening jaws | ❑ | ❑ | __________ |
| Frequent mouth breathing - while awake | ❑ | ❑ | __________ |
| Frequent mouth breathing - while asleep | ❑ | ❑ | __________ |
| Surgery to repair cleft lip and/or cleft palate | ❑ | ❑ | __________ |
| High intake of sweets | ❑ | ❑ | __________ |
| Has an orthodontist been consulted previously | ❑ | ❑ | __________ |
| If yes, who..........when.......... | | | |
| Has either parent had orthodontic treatment | ❑ | ❑ | __________ |
| Has patient ever sucked a thumb or fingers? Until what age_______ | ❑ | ❑ | __________ |

In your own words, what is the dental problem ____________________

____________________

____________________

____________________

If you have any additional concerns or questions you wish the Doctor to be aware of or you wish the Doctor to answer, please describe:

____________________

____________________

____________________

____________________