GOSHGARIAN ORTHODONTICS
FOR THE BEST

HEALTH HISTORY FORM
ADULT

Member American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

PATIENT INFORMATION REQUIRED FIELD, PLEASE FILL OUT ALL BLANK SPACES.

Name: Last: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____

Home Phone: _____ Cellphone: _____

E-mail address: _____

Occupation: _____ Employer: _____ SSN: _____

Status: Single ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐

DENTIST

Dentist: _____ Phone: _____

Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone: _____

Relation to patient: _____

REFERRAL Who may we thank for referring you to our practice?

Dentist ☐ Insurance Plan ☐ Friend: _____

Other: _____

Other family members seen here: _____

SPOUSE / CLOSEST RELATIVE

Name: Last: _____ First: _____ MI: _____

Address: _____

Home Phone: _____ Cellphone: _____ Relation: _____

FINANCIAL RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) REQUIRED FIELD, PLEASE FILL OUT ALL BLANK SPACES.

Name: Last: _____ First: _____ MI: _____ SSN: _____

Date of Birth: _____ Home Phone: _____ Cellphone: _____

Billing Address: _____

E-mail address: _____ Relation: _____

INSURANCE INFORMATION

Primary Dental Insurance: _____ Phone: _____

Address: _____

Policy Holder's Name: _____ Date of Birth: _____

Member ID: _____ Group #: _____ Employer: _____

Secondary Dental Insurance: _____ Phone: _____

Address: _____

Policy Holder's Name: _____ Date of Birth: _____

Member ID: _____ Group #: _____ Employer: _____

DENTAL HISTORY

Y N DK

Permanent or supernumerary (extra) teeth removed? Circle all that apply.

Chipped or otherwise injured primary (baby) or permanent teeth?..... ☐ ☐ ☐

Teeth sensitive to hot or cold? Teeth throb or ache? Circle all that apply.

Jaw fractured, cysts, mouth infections? Circle all that apply.

History of root canals? _____

Bleeding gums, bad taste, and mouth odor? Circle all that apply.

Does patient brush his/her teeth conscientiously? ..... ☐ ☐ ☐

Is patient self– conscious? ..... ☐ ☐ ☐

Periodontal (gum) problems?..... ☐ ☐ ☐

Has patient ever had periodontal (gum) treatment? ..... ☐ ☐ ☐

Food impaction between teeth? ..... ☐ ☐ ☐

"Gum boils", frequent canker sores, cold sores? Circle all that apply.

Abnormal swallowing habit (tongue thrusting)? ..... ☐ ☐ ☐

History of speech problems? ..... ☐ ☐ ☐

Mouth breathing habit, snoring, difficulty in breathing? Circle all that apply.

Any pain in jaw or ringing in the ears? ..... ☐ ☐ ☐

Difficulty encountered in chewing or jaw opening? ..... ☐ ☐ ☐

Tooth grinding, jaw clenching, clicking and locking? Circle all that apply.

Does the patient experience any pain soreness in the muscles of the face or around the ears? ..... ☐ ☐ ☐

Aware of loose, broken or missing restorations (fillings)? ..... ☐ ☐ ☐

Any teeth irritating check, lip, tongue, palate? ..... ☐ ☐ ☐

Concerned about spaced, crooked, protruding teeth? ..... ☐ ☐ ☐

Aware or concerned about under or over developed jaw? ..... ☐ ☐ ☐

Any relative with similar tooth or jaw relationships? ..... ☐ ☐ ☐

Any wisdom teeth problems?..... ☐ ☐ ☐

Has patient had any serious trouble associated with any previous dental treatment?..... ☐ ☐ ☐

Has patient recently been under another dentist's care?

Specialist: _____

Has patient ever had a prior orthodontic examination or treatment?..... ☐ ☐ ☐

Would patient object to wearing orthodontic appliances (braces) should they be indicated?..... ☐ ☐ ☐

Date of most recent dental exam: _____

How often does patient brush: _____

How often does patient floss: _____

Primary concerns/ reason for consultation: _____

_____

_____

_____

HEALTH HISTORY

Y N DK

Birth defects or hereditary problems? ..... ☐ ☐ ☐

Bone fractures, any major accidents? ..... ☐ ☐ ☐

Endocrine or thyroid problems? Circle all that apply.

Kidney problems? ..... ☐ ☐ ☐

Diabetes? ..... ☐ ☐ ☐

Problems with immune system? ..... ☐ ☐ ☐

Female Patients: Are you pregnant?..... ☐ ☐ ☐

Female Patients: Are you taking birth control pills? ..... ☐ ☐ ☐

Female Patients: Are you anticipating becoming pregnant? ..... ☐ ☐ ☐

Stomach ulcer, or hyperacidity? Circle all that apply.

Polio, mono, tuberculosis, pneumonia? Circle all that apply.

Hepatitis, jaundice, or liver problem? Circle all that apply.

Cardiovascular problem, (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart? Circle all that apply.

Cancer or been treated of a tumor? _____

AIDS or HIV positive? Circle all that apply.

Fainting spells, seizures, epilepsy, or neurologic problem? Circle all that apply.

High or low blood pressure? Circle all that apply.

Tires easily? ..... ☐ ☐ ☐

Vision, hearing, tasting or speech problem? Circle all that apply.

Excessive bleeding, black and blue tendency, anemia or bleeding disorder? Circle all that apply.

Mental health or behavioral problem? _____

Does patient have learning disabilities or need extra help with instructions?..... ☐ ☐ ☐

Chest pain, shortness of breath or swelling ankles? Circle all that apply.

Skin Disorder? _____

Do you need to pre-medicate for dental procedures? ..... ☐ ☐ ☐

Do you have a normal and good diet? ..... ☐ ☐ ☐

Frequent headaches, colds or sore throats? Circle all that apply.

Eye, ear, nose, throat condition? Circle all that apply.

Hay fever, asthma, sinus trouble, hives? Circle all that apply.

Allergies, or drug reactions? Explain: _____

Are you taking any medication, nutrient supplements, or non-prescription medicine? Please name them: _____

Loss of weight recently or poor appetite? Circle all that apply.

Any Operations or surgical procedures? _____

Hospitalized? Explain: _____

Other physical problems or symptoms? Explain: _____

Being treated by another care professional? Explain: _____

Date of most recent physical exam: _____

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment:

_____

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

_____

Signature of Responsible Party / Parent / Guardian **Date**