

**Health History Form**

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patients Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Preferred Name To Be Called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Name If Not Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Date of Birth If Not Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Social Security Number: \_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_

Responsible Party Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Insurance Information**

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SS #: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have duel insurance coverage please complete:

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SS #: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Dentist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Dental Cleaning / Checkup: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any future Dental procedures planned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Please Check Next To Yes or No**

Yes No Are you currently under any medical treatment?

Yes No Do you have pain, clicking and/or popping noises in the jaw?

Yes No Are you aware of either clenching or grinding of the teeth?

Yes No Do you have frequent headaches? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you have ear problems, either aches, ringing, dizziness, fullness?

Yes No Do you have difficulty breather through the nose?

Yes No Do you have habits such as nail biting, finger or thumb sucking?

Yes No Do you have speech problems, or are you in speech therapy?

Yes No Has there been a history of joint swelling, asthma, TB, Aids, Kidney,

 Liver Condition, Epilepsy, Rheumatic Fever, Other Major Illness?

If Yes to the above question, please list which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Is there a tendency to faint or become dizzy?

Yes No Are you currently taking any medications?

If Yes to the above question, please list which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you have a heart condition?

Yes No Do you pre-medicate?

If Yes to the above question, your Cardiologist name? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you have sleep apnea?

Yes No Do you smoke or chew tobacco?

**Responsible Party Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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



**This Notice Describes How Medical Information About You And / Or The Patient May Be Used And Disclosed And How You Can Get Access To This Information**

Please Review This Carefully,

The Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) is a federal program that requires that all Dental records and other individually identifiable health information used to disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPPA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPA”, we have prepared this explanation on how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

* Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
* Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
* Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternative or other health related benefits and services that may be of interest to you.

Any other use and disclosures will be made only with your written authorization. You may revoke such authorization in writing requests to the Privacy Officer.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and discloser of my protected health information to carry out treatment, payment activities and health care options.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



1. Have you had orthodontic treatment before?

**\_\_\_\_\_** Yes

**\_\_\_\_\_** No

1. What was your prior orthodontic treatment?

**\_\_\_\_\_** Traditional Braces

**\_\_\_\_\_** Plastic Aligners

1. Why are you seeking treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What are your chief concerns?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a treatment in mind?

 \_\_\_\_\_\_\_ I don’t know; I need to learn more

  **\_\_\_\_\_** Hidden Braces (behind the teeth)

 **\_\_\_\_\_** Traditional Braces

 **\_\_\_\_\_** Aligners

 **\_\_\_\_\_** Retainers

1. Why? (check all that apply)

 \_\_\_\_\_\_\_Invisible

 **\_\_\_\_\_** Colors

 **\_\_\_\_\_** Ease of use

 **\_\_\_\_\_** My friend recommend it

 \_\_\_\_\_\_\_I think this will be faster

 **\_\_\_\_\_** Minimal effort

 **\_\_\_\_\_** None of the above

1. How did you hear about this treatment?

**\_\_\_\_\_** Friend

**\_\_\_\_\_** Social Media

**\_\_\_\_\_** Commercial Dentist

**\_\_\_\_\_** Other

1. Why have you held back on treatment until now?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How often you drink or sip on non-water beverages (juices, soda, coffee, tea, win, etc)?

\_\_\_\_\_ All day

\_\_\_\_\_ Most of the day

\_\_\_\_\_ Half of the day

\_\_\_\_\_ Less than half of the day

\_\_\_\_\_ Less than 1 hour of the day

\_\_\_\_\_ Never

1. How often do you attend social events (meals with friends / colleagues / clients / work events / parties / dates / etc)?

\_\_\_\_\_ 5+ times per week

\_\_\_\_\_ 2-3 times per week

\_\_\_\_\_ 2 to 4 times per month

\_\_\_\_\_ Almost never

1. Do you speak often for work?

\_\_\_\_\_ Yes, all the time

\_\_\_\_\_ Most of the time

\_\_\_\_\_ Some of the time

\_\_\_\_\_ Never

1. Do you have any upcoming life events (wedding /engagement / graduation / speaking event / work conference / important family event) that we should be prepared for?

Dave / Event

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dave / Event

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_