



Health History Questionnaire

(ADULT PATIENTS)

Date _____

Patient Information

Last name _____ First _____ Middle _____
Patient prefers to be called _____ SSN _____ Birth date _____ Age _____ Male Female
Address _____ City _____ State _____ Zip _____
Home phone _____ Work phone _____ Cell phone _____ Email _____
Previous address (if less than 3 yrs ago) _____ City _____ State _____ Zip _____
Employer _____ Position _____ Years there _____
Patient's interests/hobbies _____
Other family members/friends treated here _____
Whom may we thank for recommending us? _____ Dentist's name _____
What is the primary concern for Dr. Bourne to address? _____

Spouse Information (if applicable)

Last name _____ First _____ Middle _____
SSN _____ Birth date _____ Relationship to patient _____
Home phone _____ Work phone _____ Cell phone _____ Email _____
Employer _____ Position _____ Years there _____

Orthodontic Insurance Information

Primary policy holder's name _____ SSN/ID _____ Birth date _____
Insurance company _____ Group number _____ Phone number _____
Insurance company address _____ City _____ State _____ Zip _____
Secondary policy holder's name _____ SSN/ID _____ Birth date _____
Insurance company _____ Group number _____ Phone number _____
Insurance company address _____ City _____ State _____ Zip _____

OVER

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Dental History

Dentist _____ City _____ Last visit date _____

Have you previously been examined/treated by an orthodontist? Y N

Describe your attitude towards orthodontic treatment _____

Please check any of the following if you have/have had:

- Injuries to the face, mouth or teeth _____
- Teeth removed by extraction _____
- Thumb, finger or lip sucking _____
- Missing or extra permanent teeth _____
- Clenching or grinding _____
- Jaw joint sounds or pain/TMJ _____
- Family history of jaw-size imbalance _____
- Tongue thrusting _____
- Speech problems _____
- Previous difficulty with dental treatment _____
- Other _____

Medical History

Physician _____ City _____ Phone _____

List any medications currently being taken _____

List any allergies to medications _____ **Are you allergic to latex?** Y N

List any other allergies _____

Have you been hospitalized for any reason? Y N If yes, please list procedure(s) and dates _____

Females: Are you pregnant/anticipating pregnancy? Y N

Please check any of the following if the patient has/has had:

- | | | | |
|---|---|--|--|
| <input type="radio"/> Abnormal bleeding | <input type="radio"/> Diabetes | <input type="radio"/> Hearing problems | <input type="radio"/> Mental health/Emotional problems |
| <input type="radio"/> Anemia | <input type="radio"/> Disease of the eyes, ears, nose or throat | <input type="radio"/> Heart Murmur | <input type="radio"/> Nervous system disorders |
| <input type="radio"/> Arthritic/Rheumatoid conditions | <input type="radio"/> Dizziness/Fainting | <input type="radio"/> Hepatitis/Liver problems | <input type="radio"/> Radiation/Chemotherapy |
| <input type="radio"/> Artificial joints/Valves/Implants | <input type="radio"/> Eating disorders | <input type="radio"/> Herpes | <input type="radio"/> Rheumatoid disorders |
| <input type="radio"/> Asthma/Respiratory problems | <input type="radio"/> Endocrine/Thyroid problems | <input type="radio"/> High blood pressure | <input type="radio"/> Tobacco use (how much?) |
| <input type="radio"/> Birth defects/Hereditary problems | <input type="radio"/> Epilepsy | <input type="radio"/> HIV/AIDS | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Cardiovascular problems | <input type="radio"/> Frequent headaches | <input type="radio"/> Immune system problems | <input type="radio"/> Vision problems |
| <input type="radio"/> Cancer/Tumor | <input type="radio"/> Gastrointestinal disorders | <input type="radio"/> Kidney problems | <input type="radio"/> Other _____ |

Patient Motivation

Orthodontic treatment can improve the overall appearance of patients' teeth and faces. Please help us to understand your wishes regarding orthodontic treatment by indicating any of the following that may apply:

How would you like your teeth to change?

- Straighten teeth
- Move upper teeth
- Move lower teeth
- Move midline of the upper teeth
- Move midline of the lower teeth
- Move upper teeth up (teeth and gums show too much)
- Move upper teeth down (teeth and gums show too little)
- Other changes desired _____

- upper
- forward
- forward
- left
- left
- left
- left

- lower
- backward
- backward
- right
- right
- right
- right

How would you like your face to change?

- Move upper lip
- Move lower lip
- Move upper jaw
- Move lower jaw
- Move chin to center it
- When the teeth are touching, make lips
- Other changes desired _____

- forward
- forward
- forward
- forward
- left
- closer together
- farther apart

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 may have made in the completion of this form. It is my responsibility to inform this practice of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees, and may, at the discretion of this practice, use the services of one or more credit reporting services. If this practice accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment and deductibles that my insurance does not cover.

Signed (parent/guardian) _____

Date _____