



Health History Questionnaire

(PATIENTS UNDER 18)

Date _____

Patient Information

Last name _____ First _____ Middle _____
 Patient prefers to be called _____ Birth date _____ Age _____ Male Female
 Address _____ City _____ State _____ Zip _____
 Home phone _____ Sibling's names and ages _____
 Grade _____ Patient interests/hobbies/sports _____
 Patient's present height _____ Birth father's height _____ Birth mother's height _____
 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? _____

Father/Guardian

Last name _____ First _____ Middle _____
 Address _____ City _____ State _____ Zip _____
 Years there _____ SSN _____ Birth date _____ Relationship to patient _____
 Home phone _____ Work phone _____ Cell phone _____ Email _____
 Previous address (if less than 3 yrs ago) _____ City _____ State _____ Zip _____
 Employer _____ Position _____ Years there _____

Mother/Guardian

Last name _____ First _____ Middle _____
 Address _____ City _____ State _____ Zip _____
 Years there _____ SSN _____ Birth date _____ Relationship to patient _____
 Home phone _____ Work phone _____ Cell phone _____ Email _____
 Previous address (if less than 3 yrs ago) _____ City _____ State _____ Zip _____
 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 _____

Has patient previously been examined/treated by an orthodontist? Y N

Describe the patient's attitude towards orthodontic treatment _____

Has the patient had any recent rapid growth? Y N How much? _____

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

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

Medical History

Physician _____ City _____ Phone _____

List any medications currently being taken _____

List any allergies to medications _____ **Is the patient allergic to latex?** Y N

List any other allergies _____

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

Females: Has menstruation begun? Y N If so, list the date _____ Is the patient pregnant? Y N

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

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

Patient Motivation

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

How would you like the patient's teeth to change?

- | | | |
|--|-------------------------------|--------------------------------|
| <input type="radio"/> Straighten teeth | <input type="radio"/> upper | <input type="radio"/> lower |
| <input type="radio"/> Move upper teeth | <input type="radio"/> forward | <input type="radio"/> backward |
| <input type="radio"/> Move lower teeth | <input type="radio"/> forward | <input type="radio"/> backward |
| <input type="radio"/> Move midline of the upper teeth | <input type="radio"/> left | <input type="radio"/> right |
| <input type="radio"/> Move midline of the lower teeth | <input type="radio"/> left | <input type="radio"/> right |
| <input type="radio"/> Move upper teeth up (teeth and gums show too much) | | |
| <input type="radio"/> Move upper teeth down (teeth and gums show too little) | | |
| <input type="radio"/> Other changes desired _____ | | |

How would you like the patient's face to change?

- | | | |
|--|---------------------------------------|-------------------------------------|
| <input type="radio"/> Move upper lip | <input type="radio"/> forward | <input type="radio"/> backward |
| <input type="radio"/> Move lower lip | <input type="radio"/> forward | <input type="radio"/> backward |
| <input type="radio"/> Move upper jaw | <input type="radio"/> forward | <input type="radio"/> backward |
| <input type="radio"/> Move lower jaw | <input type="radio"/> forward | <input type="radio"/> backward |
| <input type="radio"/> Move chin to center it | <input type="radio"/> left | <input type="radio"/> right |
| <input type="radio"/> When the teeth are touching, make lips | <input type="radio"/> closer together | <input type="radio"/> farther apart |
| <input type="radio"/> Other changes desired _____ | | |

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 child's medical status. I authorize the dental staff to perform the necessary dental services my child 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 _____