Date_____ **Confidential Responsible Party Information** A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home 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_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

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

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

Insurance Information

Policy Holder's Name_____ and Soc.Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

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

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)

BEATTIE FAMILY ORTHODONTICS

Health History Form

Physician:			Phone:		
When was the last visit?					
Have you (the patient) ever had any of the following?					
Abnormal Bleeding	Yes	No	Head/Facial Injury	Yes	No
Allergic to Latex/Metals	Yes	No	Headaches	Yes	No
Any Operations	Yes	No	Heart Trouble	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No
Cleft Lip/Palate	Yes	No	Hepatitis	Yes	No
Convulsions/Epilepsy	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	HIV/AIDS	Yes	No
Emotional Problems	Yes	No	Kidney/Liver Problems	Yes	No
Fainting/Dizziness	Yes	No	Mitral Valve Prolapse	Yes	No
Genetic Disorders	Yes	No	Rheumatic Fever	Yes	No
Handicaps/Disabilities	Yes	No	Speech/Hearing Impairment	Yes	No
Are you currently taking any drugs or medications?					
Are you allergic to any drugs or medications?					
Have you been advised to take antibiotics prior to any dental procedures?					
If yes, name of drug and method:					
Are there any other health problems?					
Family Dentist:			Last Visit:		
Have you (the patient) ever had problems with any of the following?					
Thumb or finger habits	Yes	No	Clenching or Grinding	Yes	No
Toothaches	Yes	No	Jaw Clicking or Popping	Yes	No
Gum infections	Yes	No	Jaw Stiffness	Yes	No
Teeth sensitive	Yes	No	Jaw Soreness	Yes	No
Teeth discolored	Yes	No	TMJ Problems	Yes	No
Has there ever been any injury to the face, mouth, teeth, or chin?					
Have the tonsils/adenoids been removed?					
Have you ever been informed of any missing or extra permanent teeth?					
Have you ever been evaluated for orthodontic treatment?					
What areas of your smile or your bite would you like to change?					
Are you concerned with any of the following?					
Upper teeth crowded	Yes	No	Underbite	Yes	No
Lower teeth crowded	Yes	No	Missing teeth	Yes	No
Upper teeth protrude	Yes	No	Problem with bite	Yes	No
Spacing or gaps	Yes	No	My dentist told me to come	Yes	No
What aspect of orthodontic treatment are you most concerned about?					
Quality	Cost		Discomfort	Length of time	
Have any family members had orthodontic treatment?					
Do you know anyone else who is a patient here?					
Signed:			Date:		

Thank You