New Patient Health History
Delaware Orthodontics
PLEASE FILL OUT FORM COMPLETELY

Confidential Patient Information	
First Name:	Date of Birth:
Middle Initial:	Gender:
Last Name:	Main Phone:
Street Address:	Secondary Phone:
City, State, Zip:	Email:
Parent or Guardian Name:	
Who does patient live with:	
School/Grade:	
Hobbies/Sports:	
Who referred you	

Confidential Financial Party Information			
Responsible Party			
First Name:		Address (if different):	
Last Name		City, State, Zip:	
Marital Status:		Social Security #:	
How long at address:		Date of Birth:	
Rent or Own:		Relationship to Patient:	
Main Phone:		Employer:	
2nd Phone:		Occupation:	
E-mail:		Length of Employment:	
2nd Parent Information			
First Name:		Employer:	
Last Name:		Occupation	
Address (if different):		Length of Employment:	
City, State, Zip:		Date of Birth:	
Social Security #		Phone Number:	
Relationship to Patient:		Email:	

Dental Insurance Information			
Primary Dental Insurance			
Policy Holder's Name:		Subscriber ID#:	
Insurance Company:		Group #:	
Address:		Phone #:	
City, State, Zip:		Employer:	
Subscriber Date of Birth		Relationship to Patient:	
Dual Dental Coverage:			
Secondary Dental Insurance			
Policy Holder's Name:		Subscriber ID#:	
Insurance Company:		Group #:	
Address:		Phone #:	
City, State, Zip		Employer:	
Subscriber Date of Birth:		Relationship to Patient:	

Emergency Information	
Nearest relative not living with you:	
Phone Number:	Relationship to Patient:

Please complete both sides. (Turn page over)

Dental History			
Dentist Name:		Ever had consult / treatment:	
Check up Frequency:		If so, when	
Last Dental Visit:			
Premedicate prior to dental visit	Yes / No		
Main orthodontic concern:			

Speech problems/therapy?	Yes / No	Mouth breathing?	Yes / No
Oral habits (thumb/finger habit, lip/nail biting)?	Yes / No	Snores during sleep?	Yes / No
Injury to face, jaw, teeth, or mouth?	Yes / No	Any missing or extra permanent teeth?	Yes / No
Pain, tenderness, or noise in either jaw?	Yes / No	Apprehensive about dental care?	Yes / No
Chipped or injured permanent teeth	Yes / No	Jaw fractures, cysts, mouth infections	Yes / No
Previous periodontal (gum) treatment	Yes / No	Bleeding gums	Yes / No
Abnormal swallowing (tongue thrust)	Yes / No	Is all dental work completed at this time	Yes / No
Explain any “Yes”:			

History of jaw joint problems	Yes / No	Experience soreness in the muscles of face or around ears	Yes / No
Have you been treated for “TMJ”	Yes / No	Notice clicking or popping in jaw joint	Yes / No
Has jaw ever locked	Yes / No	Do you clench your teeth	Yes / No
Explain any “Yes”:			

Medical History			
Is patient under care of a physician		Yes / No	
If so, what is being treated			
Medications taken:			
Allergies or drug reactions to:			
Latex	Yes / No	Penicillin or other antibiotics	Yes / No
Sulfa Drugs	Yes / No	Aspirin, Ibuprofen, Tylenol	Yes / No
Local anesthetics	Yes / No	Codeine or other narcotics	Yes / No
Drug allergies or sensitivities		Other	

	Yes / No	Diabetes	Yes / No
Damaged or artificial heart valves	Yes / No	Tuberculosis/Lung Disease	Yes / No
Congenital Heart Defect	Yes / No	Thyroid / Endocrine Problems	Yes / No
Heart Disease	Yes / No	Hormone Therapy	Yes / No
Liver Disease / Jaundice / Hepatitis	Yes / No	**Metal Allergy**	Yes / No
Kidney Disease	Yes / No	Nervous Disorders	Yes / No
Heart Attack/Stroke	Yes / No	Bone Disorders/Bone Loss	Yes / No
Hemophilia	Yes / No	Seizures / Epilepsy / Neurological Disease	Yes / No
HIV/AIDS	Yes / No	Asthma	Yes / No
Tonsils/Adenoids Removed	Yes / No	Respiratory problems	Yes / No
Arthritis / Joint problems	Yes / No	Persistent swollen neck glands	Yes / No
Bed wetting	Yes / No	FEMALES: Pregnant	Yes / No
Substance abuse problem (past or present)	Yes / No	Take Bisphosphonates (Fosamax, Boniva)	Yes / No
Bone fractures / trauma to face / jaw	Yes / No	Chronic fatigue	Yes / No
Prosthetic joints	Yes / No		Yes / No
Explain any “Yes”			

Yes / No	**I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.**
Yes / No	**I understand that where appropriate, credit bureau reports may be obtained.**

Signature: _____ **Date:** _____

Patient or Parent/Guardian (if under 18)