Health History Questionnaire

Dear ______________________:

We are pleased that you called our office for your orthodontic treatment. At your visit a preliminary orthodontic evaluation will be made and a preliminary diagnosis indicated. Should orthodontic treatment be suggested, diagnostic records will be prescribed. In order to save you a second visit, we have set aside the time to do the diagnostic records; please allow about 90-minutes for this visit.

We have enclosed this questionnaire in order to in order to obtain an accurate history on this patient. *Please complete the entire questionnaire and bring it with you to your appointment*; thank you.

We are looking forward to seeing you on: Day ____________, Date ____________, at Time ____________

Sincerely, ________________________________ Date ________________

Please provide us with the following information:

Patient's Last Name: ________________________, 1st ____________ MI___, Nickname: ____________ Sex: ☐M ☐F Birth Date: ________

Address: ____ ZIP________ Home Phone: ____________ Soc. Sec. No.: ____________

Years lived at above address: ______ (Previous address if less than 3 years: ____)

School/Employer: ____________________ Grade/Dept. ____________________ Years with this Employer (if adult): ______

Marital Status (or parents marital status if a child): ☐Married ☐Separated ☐Widowed ☐Divorced (If divorced, for _____ ☐months ☐years)

Father/Husband: ________________________________ Soc. Sec. No.: ____________ Home Phone: ____________

Address: ____ Work Phone: ____________

Years lived at above address: ______ (Previous address if less than 3 years: ____)

Employer: ________________________ Years with this Employer: _____ Dept: ____________ OK to contact at office? ☐Yes ☐No

Mother/Wife: ________________________________ Soc. Sec. No.: ____________ Home Phone: ____________

Address: ____ Work Phone: ____________

Years lived at above address: ______ (Previous address if less than 3 years: ____)

Employer: ________________________ Years with this Employer: _____ Dept: ____________ OK to contact at office? ☐Yes ☐No

Financially Responsible Person (check off ☒ all who will be paying on this account): ☐Patient ☐Father ☐Mother ☐Other (complete below *ONLY* if ☒Other)

Other Name: ________________________________ Relation To Pt.: ____________ Soc. Sec. No.: ____________

Address: ____ Home Phone: ____________ Work Phone: ____________

Years lived at above address: ______ (Previous address if less than 3 years: ____)

Employer: ________________________ Years with this Employer: _____ Dept: ____________ OK to contact at office? ☐Yes ☐No

Insurance: Name of Insured: ☐Patient ☐Father ☐Mother ☐Guarantor ____

Dental Insurance? ☐No

INS. Co.: ________________________ Group/Plan #: ____________ Covers Orthodontic Treatment? ☐Yes ☐No ☐?

INS. Co. Phone: ____________ Address: ________________________________ Guarantor's Birth Date: ___ - ___- xxxx

OTHER Dental Insurance? ☐No

Name of Insured: ____________________________ Soc. Sec. No.: ____________ Insured's Birth Date: ___ - ___- xxxx

INS. Co.: ____________________________ Group/Plan #: ____________ Covers TMJ Treatment? ☐Yes ☐No ☐?

INS. Co. Phone: ________________ Address: ____

In case we can't reach you, whom can we contact? Person's Name: ______________________________ Phone: ____________

Relationship to Patient: ________________ Person's Address: ____

Health History Questionnaire Instructions:

1. Please check off either Yes or No for *every* question.
2. If ☒ YES, please indicate any "specifics".
3. Please sign and date the last page and *bring this form with you to your appointment.*