Health History Form

Confidential Patient Information	
Patient Full Name:	Birth date:
Gender	Nickname:
Address:	Cell Phone:
	E-mail:
Social Security #	
Parent or Guardian Name (who patient lives with)	
If your children are under 18, please list their name and date of birth to register them for free consultations and family member discounts.	
Sibling #1	Birth date
Sibling #2	Birth date
Sibling #3	Birth date
Sibling #4	Birth date
Any immediate family members seen?	
How did you hear about our office?	
Who is filling out this form? (Name/Relation/Ph#):	
Emergency Contact (Name/Relation/Ph#):	

Confidential Financial Party Information		
Responsible Party		
Full Name:	Address:	
Main Ph#/Cell:		
Marital Status: ☐ Single ☐ Separated ☐ Parents Married ☐ Parents Divorced ☐ Domestic Partner		
Social Security #	E-mail:	
Birth date:	Relationship to patient:	
Employer:	Job Title:	
Spouse Information		
Full Name:	Address:	
Main Ph#/Cell:		
Social Security #	E-mail:	
Birthdate:	Employer:	Job Title
Relationship to patient: ☐ Biological Parent ☐Step parent ☐ Guardian ☐Other :		

Dental Insurance Information			
Primary Dental Insurance			
Policy Holder's Name:		Relationship to Patient:	
Insurance Company:		Employer:	
Group #:		Subscriber ID#:	
Secondary Dental Insurance			
Policy Holder's Name:		Relationship to Patient:	
Insurance Company:		Employer:	
Group #:		Subscriber ID#:	

Orthodontic Treatment Interest & History	
Have you had orthodontic treatment before? ☐ Yes ☐ No	If yes, year it was completed?
What is your main concern?	
Are you interested in: ☐ braces ☐ aligners ☐ whatever the Dr. recommends ☐ I don't want braces	

Dental History			
General Dentist Name:		Last Dental Visit:	
Do you require antibiotics prior to dental visits? ☐ Yes ☐ No			
Speech problems/therapy?	☐ Yes ☐ No	Mouth breathing?	☐ Yes ☐ No
Grind or clench teeth?	☐ Yes ☐ No	Any missing or extra permanent teeth?	☐ Yes ☐ No
Thumb/finger habit, lip/nail biting?	☐ Yes ☐ No	Thumb or finger habit as a child?	☐ Yes ☐ No
Injury to face, jaw, teeth, or mouth?	☐ Yes ☐ No	Abnormal swallowing (tongue thrust)?	☐ Yes ☐ No
Have you been treated for "TMJ"?	☐ Yes ☐ No	Do you notice clicking or popping in jaw joint?	☐ Yes ☐ No
Has your jaw ever locked?	☐ Yes ☐ No	Difficulty chewing or opening mouth	☐ Yes ☐ No

Medical History			
Physician Name:		Date of last physical:	
Patient Health: ☐ Poor ☐ Fair ☐ Good		Is patient under care of a physician ☐ Yes ☐ No	
If so, what is being treated			
Has patient had a serious illness/hospitalization in past 5 years ☐ Yes ☐ No If so, for what:			
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
Other:		Local anesthetics	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Damaged or artificial heart valves	☐ Yes ☐ No	Tuberculosis/Lung Disease	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Metal Allergy	☐ Yes ☐ No
Hypertension/High Blood Pressure	☐ Yes ☐ No	Bone Disorders/Bone Loss	☐ Yes ☐ No
Anemia / Blood disorder	☐ Yes ☐ No	Seizures / Epilepsy / Neurological Disease	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Tonsils/Adenoids Removed	☐ Yes ☐ No	Bone fractures / trauma to face / jaw	☐ Yes ☐ No
Take Bisphosphonates (Fosamax, Boniva)	☐ Yes ☐ No	Arthritis / Joint problems	☐ Yes ☐ No
Sinus trouble	☐ Yes ☐ No	Low blood pressure	☐ 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.

SIGNATURE : X

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Freels Orthodontics. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The photographic/video images, and/or testimonial will be used for social media, website, and/or advertising.
Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.
No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

( ) Decline
( ) You have my approval to use photographic/video images for the purposes mentioned above.

SIGNATURE : X

Acknowledgement of Receipt of Notice of Privacy Practices

Listed below are up to three persons who may be involved in my orthodontic updates which may be but not limited to: orthodontic treatment, appointments, financial information and transportation. I understand any requests to remove someone from having access would require a notice in writing.

Name	Relation	Phone No.
Name	Relation	Phone No.
Name	Relation	Phone No.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures. I understand I may request a copy of our Notice of Privacy Practices or view it online at www.freelsortho.com

SIGNATURE : X **DATE:**