smilesbypocock

Specialists in Orthodontic Care and Treatment

Health History Questionnaire

Patient Name: _____ Gender: _____ Age: ____ Birth Date: _____

Responsible Party (Child only) Parent 1: _____ Parent 2: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ Parent 1 Cell: _____ Parent 2 Cell: _____

Parent 1 Email: _____ Parent 2 Email: _____

Name of Dentist: _____ Name of Referral: _____

Name of other health care providers:(MD, any specialists): _____

What is your (or your dentist's) primary orthodontic concern? _____

_____

What is the patient's ethnic origin? _____ Parent 1? _____ Parent 2? _____

MEDICAL HISTORY- Please check **Y** or **N** for the following questions:

Is patient in good general health? Y ☐ N ☐ Is patient currently under care of a physician? Y ☐ N ☐

Has patient reached puberty? Y ☐ N ☐

▸ Any prolonged bleeding?	YES ☐	NO ☐		▸ Nervous disorders?	YES ☐	NO ☐	
▸ Diabetes?	YES ☐	NO ☐		▸ Allergies?	YES ☐	NO ☐	
▸ Bone disorders?	YES ☐	NO ☐		▸ HIV?	YES ☐	NO ☐	
▸ TB?	YES ☐	NO ☐		▸ Fainting/Dizziness?	YES ☐	NO ☐	
▸ Gland problems?	YES ☐	NO ☐		▸ Blood problems?	YES ☐	NO ☐	
▸ Epilepsy?	YES ☐	NO ☐		▸ Infections?	YES ☐	NO ☐	
▸ Hepatitis?	YES ☐	NO ☐		▸ AIDS?	YES ☐	NO ☐	
▸ Immunity problems?	YES ☐	NO ☐		▸ Arthritis?	YES ☐	NO ☐	
▸ Auto accident?	YES ☐	NO ☐		▸ Rheumatic fever?	YES ☐	NO ☐	
▸ Liver problems?	YES ☐	NO ☐		▸ Major trauma?	YES ☐	NO ☐	
▸ Asthma?	YES ☐	NO ☐		▸ Syndrome?	YES ☐	NO ☐	
▸ Autism?	YES ☐	NO ☐		▸ ADD/ADHD?	YES ☐	NO ☐	

Use the space below for information regarding any syndromes, disabilities or conditions:

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Specialists in Orthodontic Care and Treatment
www.smilesbypocock.com

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DENTAL HISTORY- Please check Y or N for the following questions:

Has the patient ever had any type of orthodontic treatment, including removable appliances? Y ☐ N ☐

Any other family members had orthodontic treatment? Y ☐ N ☐ List: _____

Do you know if the patient has any missing adult teeth? Y ☐ N ☐ or any extra teeth? Y ☐ N ☐

Any previous or ongoing thumb, finger habit? Y ☐ N ☐ If yes, how long? _____

Any previous injury to face, chin, mouth, neck or teeth? Y ☐ N ☐ _____

Any speech problems? Y ☐ N ☐ Which sounds? _____

Has patient ever had speech therapy? Y ☐ N ☐

Is patient a mouth breather? Night: YES ☐ NO ☐ Day: YES ☐ NO ☐

Tonsils removed? YES ☐ NO ☐ Adenoids removed? YES ☐ NO ☐

Does the patient (if child) have siblings? Y ☐ N ☐ Please list names/ages: _____

Any difficulty or pain when opening or closing, chewing, yawning? Y ☐ N ☐

Is patient being treated for jaw joint disorders? Y ☐ N ☐

Frequent headaches? Y ☐ N ☐

INSURANCE - Please check Y or N for the following question:

Do you have orthodontic insurance coverage? Y ☐ N ☐

Primary Insurance

Insurance Company Name: _____

Policy Holder's Name: _____

Date of Birth (Policy Holder): _____

Policy/Group Number: _____

Member/Certificate ID: _____

Secondary Insurance (If Applicable)

Insurance Company Name: _____

Policy Holder's Name: _____

Date of Birth (Policy Holder): _____

Policy/Group Number: _____

Member/Certificate ID: _____

Patient or responsible party signature:

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