KNOLL ORTHODONTICS
Health History Form

Member American Association of Orthodontists

1. PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) ( ) _____

(Cell) ( ) _____

Child Patient

Birthdate ____ /____/ _____ Age: _____

School : _____ Grade: ____

Sports: _____

Hobbies: _____

Musical Instruments: _____

Adult Patient

Birthdate ____ /____/ _____ Age: _____

Social Security #: _____

Employer: _____

Emp. Address: _____

_____

Occupation/Position: _____

How long there? _____

Where and when are the best times to reach you?

_____

2. BILLING INFORMATION

Person(s) responsible for paying this account:

_____

Billing Address:

_____

Phone Number(s):

_____

E-mail Address:

_____

Person(s) responsible for making appointments:

_____

Phone Number(s):

_____

E-mail Address:

_____

Whom may we thank for referring you?

_____

Other family members seen by us:

_____

3. PARENT OR SPOUSE INFORMATION

Marital Status: ❑ Married ❑ Widowed ❑ Divorced ❑ Single ❑ Separated

Child Patient Lives With:

❑ Both Parents ❑ Mom ❑ Dad

Other: _____

Mom's Name (or Spouse): _____

Social Security #: _____

Employer: _____

Employer Address: _____

_____

Cell #: ( ) _____

Dad's Name (or Spouse): _____

Social Security #: _____

Employer: _____

Employer Address: _____

_____

Cell #: ( ) _____

4. ORTHODONTIC INSURANCE

Insurance Company Name: _____

Address: _____

_____

Phone: ( ) _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship To Patient: _____

Insured's Date of Birth: _____ / _____ / _____

Insured's Employer: _____

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5. MEDICAL HISTORY

Patient's Physician: _____

Physician's Address: _____

_____

Physician's Phone: ( ) _____

Please describe patient's physical health:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please list all medications and other items patient is **allergic** to:

❑ None _____

_____

Please list all medications patient is taking and reasons:

_____

_____

Has patient ever had any of the following medical problems?

Y	N	Allergic to plastic	Y	N	Allergic to Latex/Metals
Y	N	Heart Murmur	Y	N	Congential Heart Defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+/AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any Stays in a Hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis	Y	N	Allergies to any Drugs

Please explain above answers or mention any other medical problems that patient has:

_____

_____

_____

6. DENTAL HISTORY

Patient's Dentist: _____

Dentist's Address: _____

_____

Dentist's Phone: ( ) _____

What are your main orthodontic concerns?

_____

_____

Has patient ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Have there ever been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has patient ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Has patient ever had any of the following dental problems?

Y	N	Mouth breather
Y	N	Lip sucking/biting
Y	N	Speech problems
Y	N	Clenching/grinding teeth
Y	N	Nail biting
Y	N	Nursing bottle habits
Y	N	Tongue thrust
Y	N	Jaw cysts, abscess, infections
Y	N	Dead teeth, root canal treatment
Y	N	Bleeding gums
Y	N	Mouth odor, bad taste
Y	N	Gingivitis, periodontal problems
Y	N	Food impaction between teeth
Y	N	Gum boils, canker sores, cold sores
Y	N	Lip, cheek, tongue biting
Y	N	Thumb, finger, tongue sucking habits
Y	N	Abnormal swallowing habit
Y	N	Jaw clicking, popping, pain
Y	N	Difficulty in chewing or breathing
Y	N	Missing or extra teeth
Y	N	Loose, broken or missing fillings
Y	N	Any teeth irritating lip, tongue
Y	N	Concern about spaced, crowded, protruding teeth
Y	N	Concern about under- or overdeveloped jaw
Y	N	Relative with similar tooth or jaw relationship
Y	N	Wisdom teeth problems

The information that I have given is correct to the best of my knowledge, and I understand that it will be held in the strictest confidence. I understand that it is my responsibility to inform this office of any changes in the patient's medical status. I also authorize the dental staff to perform the necessary dental services.

_____ Today's Date: _____

Signature