# Pacific Orthodontics Health History

C1 C2 C3 C4

| Patient Biographical Information | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | Nickname: |
| Birth date: | Gender: | Social Security #: | |
| Address: | City: | State: | Zip: |
| Main Phone: | 2nd/Cell Phone: | Email: | |
| Please list the names of any friends or family currently in the practice: | | | |
| List any sports, hobbies, or musical instruments played: | | | |
| Whom may we thank for referring you to our practice? | | | |

| Financial Party Information | | | |
|---|---|---|---|
| First Name: | Middle Initial: | Last Name: | |
| Address: | City: | State: | Zip: |
| Main Phone: | Email: | Birth date: | |
| Social Security #: | Employer: | Occupation: | |
| Length of Employment: | Work Phone: | Relationship to Patient: | |
| Do you have insurance that covers orthodontics? | If so, please name the Insurance Company: | | |

| Dental History | | | |
|---|---|---|---|
| Dentist Name: | | | |
| Check-up Frequency: | Last Dental Visit: | | |
| Has the patient had an orthodontic consult or treatment? | If so, when? | | |
| What is the patient's main orthodontic concern? | | | |
| | | | |
| Speech problems/therapy? | Brush teeth daily? | | |
| Grind or clench teeth? | Floss teeth daily? | | |
| Oral habits (thumb/finger habit, lip/nail biting)? | Fluoride treatments? | | |
| Injury to face, jaw, teeth, or mouth? | Mouth breathing? | | |
| Discomfort from teeth or gums? | Snores during sleep? | | |
| Pain, tenderness, or noise in either jaw? | Requires premedication? | | |
| Frequent headaches? | Any missing or extra permanent teeth? | | |
| Neck/shoulder pain? | Apprehensive about dental care? | | |
| Frequent sore throats? | Frequently chews gum? | | |
| If any of the above dental questions were answered "Yes," please explain: | | | |

| Medical History | | | |
|---|---|---|---|
| Physician Name: | Date of last Physical: | Patient Health: | |
| Address: | City: | State: | Zip: |
| List any medications currently being taken by the patient: | | | |
| List any drug allergies or sensitivities that the patient may have: | | | |

| | |
|---|---|
| Rheumatic Fever | Cancer |
| Tuberculosis/Lung Disease | Family History of Cancer |
| Pneumonia | Received Radiation Treatment |
| COVID-19 | Vaccinated against COVID-19 |
| Liver Disease | Growth Problems |
| Kidney Disease | Endocrine Problems |
| Heart Attack/Stroke | Hormone Therapy |
| Heart Disease | Latex |
| | Metal Allergy |
| Congenital Heart Defect | Nervous Disorders |
| Heart Murmur | Bone Disorders/Bone Loss |
| Hemophilia | Diabetes |
| Hypertension/High Blood Pressure | Seizures/Epilepsy |
| Prolonged Bleeding/Transfusion | Handicaps/Disabilities |
| Anemia | Asthma |
| HIV/AIDS | Arthritis |
| Hepatitis | Treated for Emotional Problems |
| Tonsils/Adenoids Removed | Ever Been Hospitalized |
| If any of the above medical questions were answered "Yes," please explain: | |

| Patients Under 18 | | | |
|---|---|---|---|
| Please list the name and birth date of any siblings: | | | |
| Height: | Weight: | School: | Grade: |
| Father/Guardian 1 Name: | | Mother/Guardian 2 Name: | |
| | | | |
| Has patient begun puberty? | | | |
| If patient is a girl, has menstruation begun? | | | |
| If patient is a boy, has their voice changed or have facial hair? | | | |
| Has the patient grown in the past year or has their shoe size changed recently? | | | |
| Patient's interest in treatment? | | | |
| Has either biological parent ever had orthodontic treatment? | | | |

I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Doppel to perform a complete orthodontic evaluation.

Signature: _____ Date: _____