Holliday
ORTHODONTICS
CREATING BEAUTIFUL, CONFIDENT SMILES

PATIENT INFORMATION

Date _____

Patient's Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *ZIP Code*

☐ Home ☐ Cell ☐ Work Phone _____ Birth Date _____

Email: _____ ☐Male ☐Female

RESPONSIBLE PARTY INFORMATION

Name _____
Last *First* *Middle* *Marital Status*

Relationship to Patient _____ Birth Date _____ Email:_____

Residence _____
SAME AS ABOVE ☐ *Street* *City* *State* *ZIP Code*

Mailing Address _____
SAME AS ABOVE ☐ *Street* *City* *State* *ZIP Code*

How long at this address? _____ ☐Home ☐ Cell ☐ Work Phone _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last *First* *Middle*

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Birth Date _____ ☐Home ☐ Cell ☐ Work Phone _____

EMERGENCY CONTACT INFORMATION

Name (First and Last) _____

Complete Address _____

Phone Number _____ Relationship to Patient _____

Signature (Parent's/Guardian's signature, if minor) _____ **Date** _____

I understand that, where appropriate, credit bureau reports may be obtained.

HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question)

1. **YES** **NO** Is your general health good?
2. **YES** **NO** Has there been a change in your health within the last 3 years?
3. **YES** **NO** Have you been hospitalized or had a serious illness in the last 3 years?
   Why? _____
4. **YES** **NO** Are you being treated by a physician now?
   For what? _____ Date of last medical exam? _____
5. **YES** **NO** Are you seeing a general dentist?
   Who? _____ Phone: _____
6. **YES** **NO** Has patient ever sucked thumb or fingers?
   Until what age? _____
7. **YES** **NO** Does patient clench or grind teeth?
8. **YES** **NO** Does patient have pain or clicking upon opening/closing mouth?
9. **YES** **NO** Has the patient been examined by an orthodontist before?
   By Dr. _____ on (date) _____
10. **YES** **NO** Has the patient ever had orthodontic treatment?

II. HAVE YOU EVER EXPERIENCED?

10. **YES** **NO** Chest Pain (angina)?
11. **YES** **NO** Shortness of breath, asthma?
12. **YES** **NO** Recent weight loss, fever, night sweats?
13. **YES** **NO** Persistent cough, coughing up blood?
14. **YES** **NO** Bleeding problems, bruising easily?
15. **YES** **NO** Sinus problems?
16. **YES** **NO** Difficulty swallowing?
17. **YES** **NO** Frequent vomiting, nausea?
18. **YES** **NO** Dizziness?
19. **YES** **NO** Ringing in ears?
20. **YES** **NO** Headaches?
21. **YES** **NO** Fainting spells?
22. **YES** **NO** Blurred vision?
23. **YES** **NO** Seizures?
24. **YES** **NO** Dry mouth?
25. **YES** **NO** Jaundice?
26. **YES** **NO** Joint pain, stiffness?

III. DO YOU HAVE OR HAD?

27. **YES** **NO** Heart disease?
28. **YES** **NO** Heart attack, heart defects?
29. **YES** **NO** Heart murmur?
30. **YES** **NO** Rheumatic fever?
31. **YES** **NO** Hepatitis, other liver disease?
32. **YES** **NO** High blood pressure?
33. **YES** **NO** TB, emphysema, other lung disease?
34. **YES** **NO** Osteoporosis or taken bisphosphonates?
35. **YES** **NO** AIDS or ARC?
36. **YES** **NO** Tumors, cancer?
37. **YES** **NO** Arthritis, rheumatism?
38. **YES** **NO** Latex sensitivity?
39. **YES** **NO** Herpes?
40. **YES** **NO** Thyroid, adrenal disease?
41. **YES** **NO** Diabetes?
42. **YES** **NO** Psychiatric care?
43. **YES** **NO** Radiation treatments?
44. **YES** **NO** Chemotherapy?
45. **YES** **NO** Stroke?
46. **YES** **NO** Diet medication?
47. **YES** **NO** Prosthetic heart valve?
48. **YES** **NO** Pacemaker?

IV. ARE YOU TAKING?

49. **YES** **NO** Recreational drugs?
50. **YES** **NO** Drugs, medicine, (incl aspirin)?
    PLEASE LIST _____, _____, _____
    _____, _____, _____
51. **YES** **NO** Tobacco in any form?
52. **YES** **NO** Alcohol?

V. WOMEN ONLY: YES NO Are/could you be pregnant?

VI. ALL PATIENTS: YES NO Do you have or have you had any other diseases/medical problems/allergies NOT listed on this form?

If yes, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health and/or medication.

Patient's/Guardian's Signature _____ **Date** _____