



Carlsbad Village  
ORTHODONTICS

PATIENT LAST NAME \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security No. \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ School / Grade \_\_\_\_\_

Referred by \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Patients Physician \_\_\_\_\_ Phone No \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Phone No \_\_\_\_\_

Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone No \_\_\_\_\_

Marital Status of Parents or Self: S M D W

FATHER'S NAME \_\_\_\_\_

Social Security No. \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Phone \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

Social Security No. \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Phone \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Insurance Co \_\_\_\_\_ Group No \_\_\_\_\_ Insurance Co Phone \_\_\_\_\_

Insurance Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PERSONAL INTERESTS

Does patient play any sports? (Please list) \_\_\_\_\_

Does patient play any musical instruments? \_\_\_\_\_

Other hobbies or interests? \_\_\_\_\_ Pets? \_\_\_\_\_

\_\_\_\_\_  
Printed Patient or Parent Name (if minor)

\_\_\_\_\_  
Signature of Patient or Parent (if minor)

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_

**Health History**

Your estimate of patient's health:  Good  Fair  Poor

Have there been any changes in health in the last year?  Yes  No Explain: \_\_\_\_\_

Does the patient have any history of major illness?  Yes  No Explain: \_\_\_\_\_

Have tonsils/adenoids been removed?  Yes  No Date \_\_\_\_\_

Females: Have you started menstruation?  Yes  No Date \_\_\_\_\_

Are you pregnant?  Yes  No Months into pregnancy: \_\_\_\_\_ Due Date \_\_\_\_\_

**Check any of the following for which patient has a history of:**

	Y	N		Y	N		Y	N
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic valve/limb	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Involvement	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hives or skin rash	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mental Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Troubles	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Problem	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>			

**Are you allergic to or have adverse reactions to:**

	Y	N		Y	N
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Motrin (Ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Valium (Diazepam)	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

Please list any medications and the dosage you are taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any other medical condition not mentioned above: \_\_\_\_\_

**Dental History**

	Y	N
Any history of injuries to face, mouth, or teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient ever sucked thumb, finger, or lip, pen/pencil, etc?	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have any speech problems?	<input type="checkbox"/>	<input type="checkbox"/>
Is nasal breathing difficult for patient?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient been informed of any missing or extra permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have any difficulty chewing food?	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have bleeding gums?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient ever had mouth or lip sores which were slow to heal?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient ever had Jaw pain/trauma/clicking/popping or other TMJ problems?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient dissatisfied with or sensitive about their dental appearance?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient had previous orthodontic treatment or a consult?	<input type="checkbox"/>	<input type="checkbox"/>
Has either parent had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Were extractions necessary?	<input type="checkbox"/>	<input type="checkbox"/>
What are your primary concerns that brought you in for an orthodontic evaluation?	_____	
Date of last general dental visit _____ What was done?	_____	

*I certify the above to be true to the best of my knowledge. I authorize the doctor to examine me (or my child) and obtain the necessary diagnostic information.*

\_\_\_\_\_  
Patient/ or Parent Signature Date

\_\_\_\_\_  
Doctor Signature Date

**UPDATES TO HEALTH HISTORY:**