Health History and Insurance Form for Bains Orthodontics

Patient Information

First Name _____ Middle Name (Optional) _____ Last Name _____

Preferred Name _____ Phone _____ Other Phone (Optional) _____

E-mail Address _____ Birthdate (MM-DD-YYYY) _____ Sex ☐ MALE ☐ FEMALE

Social Security Number _____

Is the patient adopted? ☐ Yes ☐ No

Parent/ Legal Gaurdian Name _____

Address

Line 1 _____ Line 2 _____

City _____ State/Province _____ Postal Code _____ Country _____

Other Family members seen by us _____ Referring party _____

Health History and Insurance Form for Bains Orthodontics

Responsible Party Info

Full Name

Cell Phone

Residence

Line 1

Line 2

City

State/Province

Postal Code

Country

Home Phone

Mailing Address (If Different)

Line 1

Line 2

City

State/Province

Postal Code

Country

If patient is under 18, please complete this section

Social Security Number

Birthdate (DD-MM-YYYY)

Relationship to Patient

Employer

Occupation

Spouse's Name

Email

Is there an addtional responsible party?

☐ Yes ☐ No

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Orthodontic Insurance Info

Insured's Name

Insured's SSN

Insurance Company

Group Number

Local Number

Phone Number

Insurance Company Address

Line 1

Line 2

City

State/Province

Postal Code

Country

Do you have dual coverage?

☐ Yes ☐ No

Insurance Company

Group Number

Local Number

Phone Number

Insurance Company Address

Line 1

Line 2

City

State/Province

Postal Code

Country

Emergency Information

Emergency Contact Name

Phone Number

Relationship to patient

Emergency Contact Address

Line 1

Line 2

City

State/Province

Postal Code

Country

Medical History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.

Physician

Phone Number

Address

Line 1

Line 2

City

State/Province

Postal Code

Country

Medical History (Contd.)

Are you taking any medication?

☐ Yes ☐ No

Comments: _____

Are you allergic to any medication?

☐ Yes ☐ No

Comments: _____

Do you have a history of any major illness?

☐ Yes ☐ No

Comments: _____

Have you had any major operations?

☐ Yes ☐ No

Comments: _____

Have you ever been involved in a serious accident?

☐ Yes ☐ No

Comments: _____

Please check any of the following that you have had or currently have:

- ☐ Abnormal Bleeding/ Hemophilia
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Hay Fever
- ☐ Bone Disorders
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gastrointestinal Disorders
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Problems
- ☐ Herpes
- ☐ Kidney Problems
- ☐ Pneumonia
- ☐ Nervous Disorders
- ☐ Prolonged Bleeding
- ☐ Radiation/Chemo Therapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Tumor or Cancer

Medical History (Contd.)

Are you pregnant?

☐ Yes ☐ No

Are you nursing?

☐ Yes ☐ No

Are there any medical conditions we have not discussed that you feel we should be aware of?

Dental History

Physician

Phone Number

What concerns you most about your teeth?

Are you presently in any dental pain?

☐ Yes ☐ No

Comments:

Have you ever experienced any unfavorable reaction to dentistry?

☐ Yes ☐ No

Comments:

Dental History (Contd.)

Have you ever lost or chipped any teeth?

☐ Yes ☐ No

Comments: _____

Have there been any injuried to face, mouth or teeth?

☐ Yes ☐ No

Comments: _____

Is any part of your mouth sensitive to temperature?

☐ Yes ☐ No

Comments: _____

Is any part of your mouth sensitive to pressure?

☐ Yes ☐ No

Comments: _____

Do you have any type of thumb or tongue habit?

☐ Yes ☐ No

Comments: _____

Are you a mouth breather?

☐ Yes ☐ No

Comments: _____

Do your teeth or jaws ever feel uncomfortable when you wake up?

☐ Yes ☐ No

Comments: _____

Are you aware of clenching your teeth during the day?

☐ Yes ☐ No

Comments: _____

Are you aware of clenching your teeth during the day?

☐ Yes ☐ No

Comments: _____

Dental History (Contd.)

Have you ever been told that you grind your teeth?

☐ Yes ☐ No

Comments:

Do you have “tension” headaches?

☐ Yes ☐ No

Comments:

Have you ever experienced chronic ringing in your ears?

☐ Yes ☐ No

Comments:

Does you have any allergies to lated

☐ Yes ☐ No

Have you ever needed pre-medication for dental procedures?

☐ Yes ☐ No

Are you currently in pain?

☐ Yes ☐ No

Have you have previous orthodontic treatment?

☐ Yes ☐ No

Do you like your smile?

☐ Yes ☐ No

Do you have any thumb or finger sucking habits?

☐ Yes ☐ No

Do you have a lip biting or sucking habit?

☐ Yes ☐ No

Do you have a nail biting habit?

☐ Yes ☐ No

Print Name

Signature

Date