



4003 Financial Parkway • Rogers, AR 72758
479-621-8229

Date _____

(Black/Blue Ink ONLY)
Health History

Patient Name _____
Last First Middle
 Address _____
Street City State Zip
 Home Phone _____ Birthdate _____ Email Address _____
 If patient is a minor, give parent's or guardian's name _____ School _____
 How did you hear about our office? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle
 Residence _____
Street City State Zip
 Mailing Address _____
Street City State Zip
 How long at this address _____ Home Phone _____ Work Phone _____ Cell Phone _____
 Previous Address (if less than 3 yrs.) _____
Street City State Zip
 Social Security # _____ Birthdate _____ Relationship to Patient _____
 Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
 Employer _____ Occupation _____ No. Years Employed _____
 Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Insurance Information

Policy Holder's Name _____ ID #/Soc. Sec. # _____
 Insurance Company _____ Group No. _____ Union Local No. _____
 Insurance Co. Address _____ Insurance Co. Phone _____
 Policy Holder's Employer _____
 Do you have dual coverage? No Yes If yes:
 Policy Holder's Name _____ ID #/Soc. Sec. # _____
 Insurance Company _____ Group No. _____ Union Local No. _____
 Insurance Co. Address _____ Insurance Co. Phone _____
 Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____
 Complete Address _____
 Phone _____ Relationship: _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL INFORMATION

	YES/NO		YES/NO
Any Heart Disease:	<input type="checkbox"/>	Rheumatic/Yellow/Scarlet Fever:	<input type="checkbox"/>
Any Respiratory Disease:	<input type="checkbox"/>	Acquired Immune Deficiency Syndrome:	<input type="checkbox"/>
Any Blood Disease:	<input type="checkbox"/>	Is Patient Under Medical Care:	<input type="checkbox"/>
Any Liver Disease:	<input type="checkbox"/>	Rheumatism or Arthritis:	<input type="checkbox"/>
Any Thyroid Disease:	<input type="checkbox"/>	A History of Fainting or Dizziness:	<input type="checkbox"/>
Any Kidney Disease:	<input type="checkbox"/>	Does the Patient have a Drug Addiction:	<input type="checkbox"/>
H.I.V. Positive:	<input type="checkbox"/>	Is the Patient Pregnant at this Time:	<input type="checkbox"/>
Any Venereal Disease:	<input type="checkbox"/>	Measles/Mumps/Chicken Pox:	<input type="checkbox"/>
Any Intestinal Disease:	<input type="checkbox"/>	Does the Patient Smoke:	<input type="checkbox"/>
Any Bone Disease:	<input type="checkbox"/>	Is the Patient in Good Health:	<input type="checkbox"/>
Any Nervous/Emotional Problems:	<input type="checkbox"/>	Is Height & Weight Normal for Age:	<input type="checkbox"/>
Any High or Low Blood Pressure:	<input type="checkbox"/>	Has the Patient ever had Fever Blisters:	<input type="checkbox"/>
Any Endocrine Problems:	<input type="checkbox"/>	Artificial Valves or Joints:	<input type="checkbox"/>
Any Problems with Wounds Healing:	<input type="checkbox"/>	Has the Patient Reached Puberty:	<input type="checkbox"/>
Any Tumors or Cancer:	<input type="checkbox"/>	If under 16 and female, what was the age of onset for menstrual cycles?	<input type="checkbox"/>
	YES/NO		YES/NO
Heart Murmur:	<input type="checkbox"/>	Asthma or Hay Fever:	<input type="checkbox"/>
Mononucleosis:	<input type="checkbox"/>	Tuberculosis:	<input type="checkbox"/>
Hepatitis:	<input type="checkbox"/>	Any Broken Bones:	<input type="checkbox"/>
Polio:	<input type="checkbox"/>	Prolonged Bleeding:	<input type="checkbox"/>
Diabetes:	<input type="checkbox"/>	Yellow Jaundice:	<input type="checkbox"/>
Anemia:	<input type="checkbox"/>	Radiation Therapy:	<input type="checkbox"/>
Hemophilia:	<input type="checkbox"/>	Chemical Therapy:	<input type="checkbox"/>
Emphysema:	<input type="checkbox"/>	Blood Transfusions:	<input type="checkbox"/>
Epilepsy:	<input type="checkbox"/>	Is the Patient Allergic to any Medications:	<input type="checkbox"/>
Psychiatric or Psychological counseling:	<input type="checkbox"/>	If yes, list Medications: _____	
Spina Bifida:	<input type="checkbox"/>		
Urogenital Anomalies:	<input type="checkbox"/>		
			YES/NO
		Is the Patient taking any Medications:	<input type="checkbox"/>
		If yes, list Medications: _____	
Are you aware of any other disease, condition, or problem not listed above that we should know about: If yes, What: _____			

DENTAL HISTORY

	YES/NO	Does the Patient Have or Ever Had Any of the Following Habits:	YES/NO	YES/NO
Has the Patient Seen a General Dentist in the Last Year:	<input type="checkbox"/>	Cheek, Tongue or Lip Chewing	<input type="checkbox"/>	Clenching Teeth:
Any Pain, clicking or discomfort In or Near the Ears:	<input type="checkbox"/>	Thumb Sucking:	<input type="checkbox"/>	Tongue Thrusting:
Are You Aware of Any "Gum" Problems:	<input type="checkbox"/>	Mouth Breathing:	<input type="checkbox"/>	Grind Teeth:
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:	<input type="checkbox"/>	Fingernail Biting:	<input type="checkbox"/>	Speech Problems:
If yes, how _____				
Has a Physician or Dentist Advised Antibiotic Before a Dental Exam? If yes, what: _____		Date of last Dental Cleaning: _____		
Have the Patient's Tonsils or Adenoids Been Removed:	<input type="checkbox"/>	Has the Patient Been Examined by an Orthodontist Before: If Yes, When: _____		
Do you Feel the Patient can Benefit from Orthodontic Treatment:	<input type="checkbox"/>	Have Other Members of the Family had Orthodontic Treatment: If Yes, Were You Happy With the Results: _____		
Is the Patient Happy with Their "SMILE":	<input type="checkbox"/>	If No, Why: _____		
Does the Patient Want to Improve Their "SMILE" and "BITE":	<input type="checkbox"/>	What is your chief concern/what would you like orthodontic treatment to accomplish: _____		
Would the Patient Mind Wearing "BRACES":	<input type="checkbox"/>			

OTHER INFORMATION

Dentist Name: _____ (First/Last Name Please)	Sports or Hobbies: _____ (First/Last Name Please) (Mo/Day/Yr)
Physician Name: _____ (First/Last Name Please)	Other Children: _____ Birthday: _____
	Other Children: _____ Birthday: _____
	Other Children: _____ Birthday: _____

FOR OFFICE USE ONLY
