HEALTH HISTORY

Patient Name _____ Date_____
General Dentist _____ City _____
Family Physician _____ City _____
Date of last dental check-up _____
Has there been any major illness or hospitalization this past year? _____
Comments _____
Have tonsils and adenoids been removed? No Yes At what age? _____
List any injuries to the face, mouth, or jaws: _____
Have you experienced any tenderness in the jaw or jaw joints? No Yes
Comments _____
Have you been informed of any missing or extra teeth? No Yes _____
Has there been any previous orthodontic treatment? No Yes _____
Comments _____

DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS

____Clenching/Grinding Teeth ____ Speech Problems ____ Nail Biting
____ Thumb/Finger Sucking ____ Mouth Breather ____ Lip Biting
Comments _____

PLEASE MARK ALL THE FOLLOWING THAT APPLY

____Diabetes
____ Pneumonia
____ Heart Trouble
____ Rheumatic Fever
____ Bone Disorder
____ Hormone Problems
____ Severe Headaches
____ Tuberculosis
____ Anemia
____ Epilepsy
____ Asthma
____ Kidney Problems
____ Blood Transfusion
____ Cancer / Chemotherapy
____ Abnormal Bleeding
____ HIV / AIDS
____ Sinus Problems
____ Fainting / Dizziness
____ Liver Problems
____ Nervous System
____ Fever Blisters/Herpes

Please discuss any serious illness or operations not mentioned above: _____
_____
Please list any drugs currently taking: _____
Please list any allergies or drug sensitivities: _____
Do you have frequent colds, sore throats, or ear infections? No Yes _____

AUTHORIZATION AND RELEASE

I certify that the information that I have given on this form is correct to the best of my knowledge. I understand that I should inform this office of any changes in this patient's medical status. I authorize Dr. Key to release any information Including the diagnosis and the records of any treatment rendered to third party payers and/or health care practioners that I may designate.

_____ _____
signature of patient or parent if a minor date

KEY ORTHODONTICS
NEW PATIENT INFORMATION FORM

Patient Full Name_____ Likes to be called_____
Street address_____ City_____ Zip_____
Age_____ Date of Birth___/___/_____ Sex: M F Adopted
Home phone (_____) _____
School _____Grade _____ Home School _____
Are you involved in a sport or band?_____
Names & Ages of siblings _____
Who may we thank for referring you to our office? _____
Reason for this visit (chief complaint) _____
If this is for an **ADULT PATIENT**, please list the following:
Employer:_____ Work Phone:_____
Dental Insurance in Force:_____

Father's Name _____ Cell Phone (_____) _____
Address if different than above _____
Employed by _____ Work Phone (_____) _____
Social Security No. _____-_____-_____ Dental Insurance in force? _____
Name of Insurance Co. _____ Group No. _____

Mother's Name _____Cell Phone (_____) _____
Address if different than above _____
Employed by _____Work Phone _____
Social Security No. _____-_____-_____ Dental Insurance in force? _____
Name of Insurance Co. _____Group No._____

Other responsible party _____
Address and phone no. _____
Insurance Co. _____ Group No._____
Relationship to patient _____

Preferred phone number for appointment reminders _____
E-mail reminders _____

PLEASE FILL OUT HEALTH HISTORY ON OTHER SIDE OF THIS PAGE

This area to be completed by office

EXAM DATE_____ FEE ESTIMATE_____

DENTIST_____ RECALL DATE_____

FINDINGS:_____