Holliday
ORTHODONTICS
CREATING BEAUTIFUL, CONFIDENT SMILES

PATIENT INFORMATION

Date _____

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

Address _____
Street *City* *State* *Zip*

Home Phone _____ Birth Date _____ Social Security # _____

Male or Female _____ If patient is minor, give parent or guardian's name _____

Patient: _____ Responsible Party: _____
Email Address *Email Address*

RESPONSIBLE PARTY INFORMATION

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

Residence _____
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street *City* *State* *Zip*

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last *First* *Middle*

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

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue: _____
Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

EMERGENCY INFORMATION

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

Signature (Parent'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 years?
3. **YES** **NO** Have you been hospitalized or had a serious illness in the last three years?
   Why?_____
4. **YES** **NO** Are you being treated by a physician now?
   For what?_____
   Date of last medical exam? _____Date of last dental appt? _____
5. **YES** **NO** Are you in pain now?
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 closing mouth?
9. **YES** **NO** Has any member of the family had orthodontic treatment?
   Who? _____
10. **YES** **NO** Has the patient been examined by an orthodontist before? By Dr. _____ Date:_____

DENTIST:_____
PHONE:_____
PHYSICIAN:_____
PHONE:_____

II. HAVE YOU EXPERIENCED?

11. **YES** **NO** Chest pain (angina)?
12. **YES** **NO** Swollen ankles?
13. **YES** **NO** Shortness of breath, asthma?
14. **YES** **NO** Recent weight loss, fever, night sweats?
15. **YES** **NO** Persistent cough, coughing up blood?
16. **YES** **NO** Bleeding problems, bruising easily?
17. **YES** **NO** Sinus Problems?
18. **YES** **NO** Difficulty swallowing?
19. **YES** **NO** Diarrhea, constipation, blood in stools?
20. **YES** **NO** Frequent vomiting, nausea?
21. **YES** **NO** Difficulty urinating, blood in urine?
22. **YES** **NO** Dizziness?
23. **YES** **NO** Ringing in ears?
24. **YES** **NO** Headaches?
25. **YES** **NO** Fainting spells?
26. **YES** **NO** Blurred vision?
27. **YES** **NO** Seizures?
28. **YES** **NO** Excessive thirst?
29. **YES** **NO** Frequent urination?
30. **YES** **NO** Dry mouth?
31. **YES** **NO** Jaundice?
32. **YES** **NO** Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD?

33. **YES** **NO** Heart disease?
34. **YES** **NO** Heart attack, heart defects?
35. **YES** **NO** Heart murmur?
36. **YES** **NO** Rheumatic fever?
37. **YES** **NO** Stroke, hardening of arteries?
38. **YES** **NO** High blood pressure?
39. **YES** **NO** TB, emphysema, other lung disease?
40. **YES** **NO** Hepatitis, other liver disease?
41. **YES** **NO** Stomach problems, ulcers?
42. **YES** **NO** Family history of diabetes, heart problems, tumors?
43. **YES** **NO** ALLERGIES: to drugs, foods, medications, anesthetics?(Please list) _____
44. **YES** **NO** AIDS or ARC?
45. **YES** **NO** Tumors, cancer?
46. **YES** **NO** Arthritis, rheumatism?
47. **YES** **NO** Latex sensitivity?
48. **YES** **NO** Skin diseases?
49. **YES** **NO** Anemia?
50. **YES** **NO** VD(syphillis or gonorrhea)?
51. **YES** **NO** Herpes?
52. **YES** **NO** Kidney, bladder disease?
53. **YES** **NO** Thyroid, adrenal disease?
54. **YES** **NO** Diabetes?

IV. DO YOU HAVE OR HAVE HAD?

55. **YES** **NO** Psychiatric care?
56. **YES** **NO** Radiation treatments?
57. **YES** **NO** Chemotherapy?
58. **YES** **NO** Prosthetic heart valve?
59. **YES** **NO** Diet medication?
60. **YES** **NO** Hospitalization?
61. **YES** **NO** Blood transfusions?
62. **YES** **NO** Surgeries?
63. **YES** **NO** Pacemaker?
64. **YES** **NO** Contact lenses?

V. ARE YOU TAKING?

65. **YES** **NO** Recreational drugs?
66. **YES** **NO** Drugs, medicine, (incl aspirin)?
67. **YES** **NO** Tobacco in any form?
68. **YES** **NO** Alcohol?

PLEASE LIST _____, _____, _____
_____, _____, _____

VI. WOMEN ONLY:

69. **YES** **NO** Are you or could you be pregnant or nursing?
70. **YES** **NO** Taking birth control pills?

VII. ALL PATIENTS:

71. **YES** **NO** Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, 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 Signature _____ Date_____

RECALL REVIEW:

1. Patient's / Guardian Signature _____ Date _____
2. Patient's / Guardian Signature _____ Date _____