

# New Patient Health History – Clauss Orthodontics

Date: \_\_\_\_\_

Patient Biographical Information			
First Name:	Last Name:	Nickname:	Adopted? Yes No
Birthdate:	Gender:	Home Phone:	
Address:	City:	State:	Zip:

Financial Party Information	
Father/Guardian Name:	Mother/Guardian Name:
Father/Guardian Address if different from above:	Mother/Guardian Address if different from above:
Father's Occupation/Employer:	Mother's Occupation/Employer:
With whom does patient reside?	Legal Guardian/Custodian:
Parent Marital Status (if <18): <input type="checkbox"/> Married / Re-married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	
Father/Guardian Email: Want appt. reminder? Yes No	Mother/Guardian Email: Want appt. reminder? Yes No
Father/Guardian Cell #: Want appt. reminder? Yes No	Mother/Guardian Cell #: Want appt. reminder? Yes No
Please list the name(s) and birthdate(s) of any siblings:	

Referral Information		
Please list the names of any friends or family currently in the practice:		
Who may we thank for referring you to our practice?		
<b>Please let us know of the ways you are familiar with Clauss Orthodontics: (Please check ALL that apply)</b>		
<input type="checkbox"/> Family Dentist/Physician referral: _____ <input type="checkbox"/> Friend / Patient referral: _____ <input type="checkbox"/> Clauss Orthodontics staff referral: _____ <input type="checkbox"/> Invisalign web search Website	<input type="checkbox"/> School referral <input type="checkbox"/> Mail Postcard <input type="checkbox"/> Ad at school <input type="checkbox"/> Print ad	<input type="checkbox"/> Community Event <input type="checkbox"/> Sports Team Sponsorship <input type="checkbox"/> Drive by / Signage <input type="checkbox"/> Other: _____

Dental History		
Dentist Name:		
Check-up Frequency:	Last Dental Cleaning:	
Speech problems/therapy? Yes No	Frequently chews gum? Yes No	Clicking jaw joint? Yes No
Grind/clench teeth habitually? Yes No	Injury to face/jaw/teeth/mouth? Yes No	Had any teeth removed? Yes No
Oral finger/thumb/nail biting habits? Yes No	Mouth breathing? Yes No	Snores during sleep? Yes No
Discomfort in teeth or gums? Yes No	Pain in/near your ears? Yes No	Frequent headaches? Yes No
Premedication before dental treatment? Yes No	Neck/shoulder pain? Yes No	<b>Oral Hygiene Habits</b>
Any missing or extra permanent teeth? Yes No	Frequent sore throats? Yes No	Brush teeth daily? Yes No
Constant sore or bleeding gums? Yes No	Difficulty chewing/swallowing food? Yes No	Use fluoride rinse daily? Yes No
Apprehensive about dental care? Yes No	Pain or tenderness in either jaw? Yes No	Floss teeth daily? Yes No
If any of the above dental questions (not including Oral Hygiene Habits) were answered "Yes," please explain:		
Does patient play a musical instrument with his/her mouth? If yes, please list all:		

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

<b>Medical History</b>			
Physician Name:		Date of last Physical:	
Patient Health:			
Is patient presently under a physician's care?		If yes, please explain:	
List any medications currently being taken by the patient:			
List drug allergies, latex allergy, or sensitivity:			
Father's Height:		Mother's Height:	
Rheumatic Fever	Yes No	Cancer	Yes No
Tuberculosis/Lung Disease	Yes No	Liver Disease	Yes No
Had Radiation Treatment	Yes No	Hemophilia	Yes No
High Blood Pressure	Yes No	Anemia	Yes No
Prolonged Bleeding/Transfusion	Yes No	Hepatitis	Yes No
Treated for Emotional Problems	Yes No	Heart Murmur	Yes No
Extensive X-ray Therapy	Yes No	Pneumonia	Yes No
Operations/Injuries of Head/Neck	Yes No	Heart Disease	Yes No
Congenital Heart Defect	Yes No	Diabetes	Yes No
Handicaps/Disabilities	Yes No	Asthma	Yes No
Rheumatism or Arthritis	Yes No	HIV/AIDS	Yes No
Venereal Disease	Yes No	Blood Disease	Yes No
Stomach or Intestinal Disease	Yes No	History of fainting	Yes No
Night Sweats w/ weight loss/cough	Yes No	Currently dieting	Yes No
Slow Healing Wounds?	Yes No		If female, are you pregnant? Yes No
If any of the above medical questions were answered "Yes," please explain:			
Has patient been ill for more than 5 days in the last year?		If yes, please explain:	

<b>Orthodontic History</b>			
Has the patient had an orthodontic consult or treatment?		Yes No	If so, when?
What is the main orthodontic concern?			
Does any member of the family or close relatives have similar arrangement of teeth or jaws?		Yes No	
Who first noticed the need for orthodontic treatment?			
<input type="checkbox"/> Parents		<input type="checkbox"/> Dentist	
<input type="checkbox"/> Patient		<input type="checkbox"/> Other: _____	
Is the patient concerned about the appearance of his/her teeth?		Yes No	
Has the patient ever been teased about the appearance of his/her teeth?		Yes No	
What is the patient's attitude toward wearing orthodontic appliances?			
<input type="checkbox"/> Eagerness		<input type="checkbox"/> Willingness	
<input type="checkbox"/> Complacency		<input type="checkbox"/> Resignation	
<input type="checkbox"/> Antagonism			
Please rank the order of importance in your selection of orthodontic treatment, with 1 being "highest importance" and 4 being "least importance".			
___ Results		___ Financial Arrangements	
___ "Clear" treatment options – Invisalign or clear braces		___ Doctor / Staff Experience	

<b>Patients Under 18</b>			
For girls, has menstruation begun? Yes No Age: _____		For boys, has their voice changed or have facial hair? Yes No Age: _____	
Has the patient experienced a sudden increase in height?		Yes No	

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient (if <18yr old): \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_