Margolis Orthodontics

Medical/Dental History Form

Patients Last Name:_____ First:_____ M.I._____ Date:_____
Date of Birth:_____ Age:_____ Sex:_____ Home Phone:_____
Patients Address:_____ City:_____ State:_____ Zip:_____
Patients Dentist:_____ Referred By:_____ Patients School:_____
Hobbies/Sports:_____ Musical Instrument Played:_____
Other:_____
Brothers/Sisters:_____

Mother/Step-Mother/Guardian Last Name:_____ First: _____ Middle:_____
Address:_____ City:_____ State:_____ Zip:_____
Occupation:_____ Employer:_____ Work Phone:_____

Father/Step-Father/Guardian Last Name:_____ First:_____ Middle:_____
Address:_____ City:_____ State:_____ Zip:_____
Occupation:_____ Employer:_____ Work Phone:_____
In case we cannot reach you: Person to contact_____ Phone #_____

Medical History

Health Quality: ☐ Good ☐ Fair ☐ Poor **Allergies**: ☐ Food ☐ Drug ☐ Latex ☐ Metal ☐ Other

Has the patient had any of the following: (Please Circle)

Hepatitis	Frequent Headaches	Excessive bleeding	Sinus problems	Nail biting
Diabetes	Heart Murmur	Thyroid problems	Throat infections	Teeth grinding
Epilepsy	Rheumatic fever	Artificial joints	Immune disorder	Lip or tongue biting
Heart Disease	Frequent colds	Kidney problems	Difficulty breathing	Speech impairment
Arthritis	Liver disease	Dizziness/fainting	Bleeding gums	Mouth breathing
Hemophilia	Convulsions/seizures	Cold sores	ADD/ADHD	Tonsils/adenoids
TB	Thumb/finger sucking	AIDS/HIV	Hepatitis	

Please Explain:_____
Physician:_____ Under Physician's Care at Present? (Y or N)_____
For What:_____
List Drugs Regularly Taken & Reason:_____

Dental History

Last Dental Visit:_____ Dental Work Being Done Now?_____ If Yes What?_____
Has Patient Ever Received a Blow to the Teeth or Jaw?_____ If Yes, Explain:_____
Has the Patient had Orthodontic Treatment or Evaluation?_____ If Yes, By Whom?_____

What do you feel are the Orthodontic Problems? ☐ Alignment of Teeth ☐ Dental Protrusion ☐ Facial Features
Other:_____
Additional Comments:_____

Orthodontic Insurance

PRIMARY

Insurance Co. Name: _____
Insurance Co. Address:_____
Insurance Co. Phone #: _____
Group #: _____
Subscriber ID #: _____
Insured's Name: _____
Insured's Relationship to Patient: _____
Insured's Date of Birth: _____
Insured's Employer: _____

SECONDARY

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group #: _____
Subscriber ID #: _____
Insured's Name: _____
Insured's Relationship to Patient: _____
Insured's Date of Birth: _____
Insured's Employer: _____

I certify that I have answered the above questions to the best of my ability. I will not hold Margolis Orthodontics or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for the cost of x-rays and other records taken at the time of consultation and/or diagnosis.

_____ _____
Signature of Patient (Parent or Guardian if Patient is a Minor) *Date*