Health History Form

Confidential Patient Information			
Patient Full Name:		Birth date:	
Gender		Nickname:	
Address:		Cell Phone:	
		E-mail:	
Social Security #			
Parent or Guardian Name (who patient lives with)			

If your children are under 18, please list their name and date of birth to register them for free consultations and family member discounts.

Sibling #1		Birth date	
Sibling #2		Birth date	
Sibling #3		Birth date	
Sibling #4		Birth date	

Any immediate family members seen? ☐ **NO** ☐ **YES, list:**

How did you hear about our office?

Who is filling out this form? (Name) | Ph No:

Emergency Contact: | **Relation:** | **Ph:**

Confidential Financial Party Information			
Responsible Party Information		Address:	
Full Name:			
Main Ph#/Cell:	May we text you? Type Yes or No		
Marital Status: Type a response from list		Single, Parents Married, Parents Divorced, Married, Separated, Domestic Partnership	
E-mail:		SSN:	
Birth date:		Relationship to patient:	
Employer:		Job Title:	
Spouse Information		Address:	
Full Name:			
Main Ph#/Cell:	May we text you? Type Yes or NO		
E-mail:		SSN:	
Birthdate:	Employer:	Job Title	
Relationship to patient:	Biological Parent, Step parent, Guardian	Other :	

Other:

Full Name:		Birth date:	
Main Ph#/Cell:		Relationship to patient:	
		Biological Parent, Step parent, Guardian	Other :

Dental Insurance Information

Primary Dental Insurance Info: Type an X to select ☐ **No Insurance**

Policy Holder's Name:		Relationship to Patient:	
Insurance Company:		Employer:	
Group #:		Subscriber ID#:	

Secondary Dental Insurance Info

Policy Holder's Name:		Relationship to Patient:	
Insurance Company:		Employer:	
Group #:		Subscriber ID#:	

Orthodontic Treatment Interest & History

Have you had orthodontic treatment before? ☐ Type Yes or No	If yes, year it was completed?
What is your main concern?	

Are you interested in: Type an X to select ☐ Braces ☐ Aligners ☐ I don't know ☐ Whatever Dr.Freels recommends ☐ I don't want braces

Dental History

General Dentist Name:		Last Dental Visit:	
Do you require antibiotics prior to dental visits?			

Type an X next to any that apply			
Grind or clench teeth?	☐ Yes	Mouth breathing?	☐ Yes
Thumb/finger habit, lip/nail biting?	☐ Yes	Any missing or extra permanent teeth?	☐ Yes
Injury to face, jaw, teeth, or mouth?	☐ Yes	Thumb or finger habit as a child?	☐ Yes
Have you been treated for "TMJ"or lock jaw?	☐ Yes	Abnormal swallowing (tongue thrust)?	☐ Yes
Speech problems/therapy?	☐ Yes	Do you notice clicking or popping in jaw joint?	☐ Yes
		Difficulty chewing or opening mouth	☐ Yes

Medical History

Physician Name:		Date of last physical:	
Patient Health:		Is patient under care of a physician	☐ Yes ☐ No
If so, what is being treated			
Has patient had a serious illness/hospitalization in past 5 years ☐ Type: Yes or No		If yes, for what:	

Medications taken:

Allergies or drug reactions to:

Type an X next to any that apply			
Latex	☐ Yes	Penicillin or other antibiotics	☐ Yes
Sulfa Drugs	☐ Yes	Aspirin, Ibuprofen, Tylenol	☐ Yes
Local anesthetics	☐ Yes	Codeine or other narcotics	☐ Yes
Other:		Local anesthetics	☐ Yes
Heart Murmur	☐ Yes	Diabetes	☐ Yes
Damaged or artificial heart valves	☐ Yes	Tuberculosis/Lung Disease	☐ Yes
Congenital Heart Defect	☐ Yes	Cancer	☐ Yes

Type an X next to any that apply

Heart Disease		Yes	Metal Allergy		Yes
Hypertension/High Blood Pressure		Yes	Bone Disorders/Bone Loss		Yes
Anemia / Blood disorder		Yes	Seizures / Epilepsy / Neurological Disease		Yes
HIV/AIDS		Yes	Asthma		Yes
Tonsils/Adenoids Removed		Yes	Bone fractures / trauma to face / jaw		Yes
Take Bisphosphonates (Fosamax, Boniva)		Yes	Arthritis / Joint problems		Yes
Sinus trouble		Yes	Low blood pressure		Yes

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

SIGNATURE : X

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Freels Orthodontics. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The photographic/video images, and/or testimonial will be used for social media, website, and/or advertising.
Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.
No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Decline
Approved -You have my approval to use photographic/video images for the purposes mentioned above.

Type Approve or Decline

SIGNATURE : X

Acknowledgement of Receipt of Notice of Privacy Practices

Listed below are up to three persons who may be involved in my orthodontic updates which may be but not limited to: orthodontic treatment, appointments, financial information and transportation. I understand any requests to remove someone from having access would require a notice in writing.

Name		Relation		Phone No.	
Name		Relation		Phone No.	
Name		Relation		Phone No.	

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.
I understand I may request a copy of our Notice of Privacy Practices or view it online at www.freelsortho.com

SIGNATURE : X