

WELCOME to Quimby and Collins Orthodontics! We are pleased that you contacted our office for an orthodontic evaluation. Please complete the questionnaire and bring it with you to your appointment.

Patient's Name: Last _____ First _____ MI _____ Gender _____
 Birth Date _____ Age _____ SSN _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 Employer _____ Position _____
 Employer Address _____ City _____ State _____ Zip _____

Email address for reminder emails: _____

If your insurance pays the provider directly we will gladly submit the insurance for you. All requested information must be completed in order to submit to your insurance. Please bring verification of your insurance to your consultation. If your insurance pays the subscriber, we will provide you with the insurance claim forms for your submission. We will not accept this insurance.

SUBSCRIBER'S NAME _____ Relationship to patient _____
 SSN _____ Date of Birth _____ Marital Status _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____

Employer _____ Position _____
 Employer Address _____ City _____ State _____ Zip _____

Dental Insurance Co. _____ Phone _____ Group # _____
 ID# _____

Health History Questionnaire

Family physician name _____ Date of your last visit to this physician _____
 Date of last complete physical exam _____ Examining doctor's name _____
 What is your approximate height? _____ ft _____ in. What is your approximate weight? _____ lbs.

Do you smoke or use any tobacco products? _____ Do you use any non-prescription drugs? _____
 Have you ever taken the drug Phen-fen and or Redux? _____

History Of Problems:	YES	NO	History of Problems:	Yes	NO
Nose/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIVpositive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			

If YES is checked, please list the specific problem(s):

Please list current medications:

Females:

Are you pregnant now or do you think you may be? ___ Do you anticipate becoming pregnant? _____

Dental History:

Name of your family dentist: _____ Date of your last visit: _____

How did you hear about us? _____

Today's chief concern: _____

History of:	YES	NO	
Tooth injury	<input type="checkbox"/>	<input type="checkbox"/>	Chipped ___ Broken ___ Lost ___
Jaw injury	<input type="checkbox"/>	<input type="checkbox"/>	Age ___
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Usually ___ Sometimes ___ Rarely ___ When: ___ Brushing ___ Flossing ___ Eating
Oral disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers ___ Sores ___ Cancer ___
Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	During the day ___ During the night ___
Clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>	During the day ___ During the night ___
Oral habits	<input type="checkbox"/>	<input type="checkbox"/>	Thumb sucking ___ Finger sucking ___ Tongue thrusting ___ Nail biting ___
Jaw joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Right TMJ: ___ Constant ___ Periodic When you: ___ chew ___ talk ___ open ___ close Left TMJ: ___ Constant ___ Periodic When you: ___ chew ___ talk ___ open ___ close
Jaw joint noises	<input type="checkbox"/>	<input type="checkbox"/>	Right: ___ clicking ___ popping ___ grating ___ Left: ___ clicking ___ popping ___ grating ___
Jaw joint locking	<input type="checkbox"/>	<input type="checkbox"/>	Right: ___ when open ___ when closed ___ Left: ___ when open ___ when closed ___

Have you had:	Yes	NO	Explain Treatment	Date	Doctor
Periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Endodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Oral Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prosthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

I hereby certify that I have reviewed the above medical and dental history and agree it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes.

Signature of person filling out this health history form _____ Date _____

Signature of doctor who reviewed this form _____ Date _____