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Severna Park, MD 21146
410- 544-0072

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Chestertown, MD 21620
410-778-0702

New Patient Health History Form

Patient's Name: _____ Nickname: _____ Sex: M / F

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Date of Birth: _____ Age: _____ School: _____ Grade: _____

Family Dentist: _____ Family Physician: _____

Primary Orthodontic Concern: _____

Whom May We Thank for referring you to Our Practice: _____

Responsible Party Information (Please list insurance holder first)

Responsible Party #1: _____ Marital Status: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

Home #: _____ Cell#: _____ SSN#: _____/_____/_____

Employer: _____ Location: _____ Work Phone: _____

Email Address: _____

Responsible Party #2: _____ Marital Status: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____

Home #: _____ Cell#: _____ SSN#: _____/_____/_____

Employer: _____ Location: _____ Work Phone: _____

Email Address: _____

In case of EMERGENCY, Whom should we contact? (other than parent/guardian)

Name: _____ Phone # _____

Health Questionnaire

Is Child currently under doctor's care? Y / N Condition: _____
Current Medication reason for taking: _____
Allergies: _____
Please circle all conditions that apply to your child:

						Injury to:		
Arthritis	No	Yes	Hepatitis	No	Yes	Face	No	Yes
Diabetes	No	Yes	Kidney Disease	No	Yes	Head	No	Yes
Rheumatic Fever	No	Yes	Sleep Problems	No	Yes	Teeth	No	Yes
Heart Problems	No	Yes	Sore Throats	No	Yes			
Hemophilia	No	Yes	Pregnancy	No	Yes			
Adenoids Removed?	No	Yes	Bleeding	No	Yes			
Tonsils Removed?	No	Yes						

PATIENT'S SIBLINGS:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Dental Questionnaire

ORAL HABITS

Clenching & Grinding of Teeth:	No	Yes
Finger or Thumb Sucking:	No	Yes
When Stopped? _____		
Chewing Difficulties:	No	Yes
Speech Problems:	No	Yes
Gagging:	No	Yes

Previous Orthodontic Treatment: No Yes
Other Family Members who have had Orthodontic Treatment: _____
_____

Jaw Joint Problems:

Clicking & Popping	No	Yes
Pain	No	Yes
Facial Pain	No	Yes

Do your gums bleed: No Yes
How many times per day do you brush: _____
Do you floss: No Yes

Date of last dental visit: _____

Growth and Development

Has there been recent rapid growth	No	Yes
Has there been a recent decline in growth	No	Yes

Height _____
Weight _____

Are there any other problems, questions, or concerns not addressed on this form that you think we should be aware of?

_____

_____

Dental Insurance Information Form

This form is for DENTAL coverage only. The information you provide will be used to verify your orthodontic benefit, so please fill out this form completely. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated. Without this information we are unable to file your claim.

Patient Name: _____ Patient's DOB: _____

Primary Insurance Co Name: _____ Phone # _____

Insurance Co. Address: _____City _____State _____ Zip _____

Subscriber's Full Name: _____Relationship to Patient:_____ DOB: _____

Subscriber's Address: _____City _____State_____ Zip_____

Social Security # _____Subscriber ID # _____Group #_____

Employer: _____ Work Phone # _____

Secondary Insurance Co Name: _____ Phone # _____

Insurance Co. Address: _____City _____State _____ Zip _____

Subscriber's Full Name: _____Relationship to Patient:_____ DOB: _____

Subscriber's Address: _____City _____State_____ Zip_____

Social Security # _____Subscriber ID # _____Group #_____

Employer: _____ Work Phone # _____

****OFFICE USE ****

Ins. Co. _____ Date of Call _____ Name of Representative _____
Effective Date _____ Waiting Period _____ Deductible _____ Age Limit _____
Lifetime Benefit _____ Has Any Benefit Been Used? _____
Benefit Paid? Monthly – Quarterly – Annually – Other _____ Automatic? Yes or No
Benefit Coordination (if two): Standard or Non Duplication Does Birthday Rule Apply? Yes or No
Benefit Paid to: Subscriber or Provider

Ins. Co. _____ Date of Call _____ Name of Representative _____
Effective Date _____ Waiting Period _____ Deductible _____ Age Limit _____
Lifetime Benefit _____ Has Any Benefit Been Used? _____
Benefit Paid? Monthly – Quarterly – Annually – Other _____ Automatic? Yes or No
Benefit Coordination (if two): Standard or Non Duplication Does Birthday Rule Apply? Yes or No

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Banding Date: _____Procedure: _____Treatment Fee: _____Months of Tx:_____