Children's Dental Center of New Hampshire and Orthodontics Too

Health History

Reviewed: _____ Date: _____

Name: _____ Birth Date: ____/____/_____
First Middle Last

Phone # for text confirmations: (_____) _____ Nickname/Preferred Name: _____

Preferred email: _____

Dentist's Name & Phone: _____

Date of Last Visit/Cleaning: _____/_____/_____ Date of Last Radiographs: _____/_____/_____

Need for Restorative Work (Fillings/Crowns): Yes No
Explain:_____

Orthodontic History

●Do you have a history of orthodontic work in the past? Yes No If Yes, Date: ____/____/_____

●Have you had orthodontic consults before? Yes No Offices' Names: _____

●Please circle any parafunctional habits: Clenching Grinding Thumbsucking Nail Biting

●Do you have any history of temporomandibular joint (TMJ) issues: Yes No Any Treatment: _____

Medical History

●Any medications? Yes No
List medications: _____

●Hospitalizations or surgeries? Yes No
If yes, explain: _____

●Allergies to the following? LATEX Food / Dyes Nickel / Stainless Steel Other:_____

●Allergies to any medications? Yes No
Explain: _____

PLEASE *CHECK YES OR NO* REGARDING YOUR HISTORY OF ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO	
		Allergies to Medications			Celiac Disease			Hearing Problems
		Asthma / Airway Issues			Seizures			Heart Disease/Heart Murmur
		Bruising Easily/Excessive Bleeding			Diabetes			Latex Allergy
		Cancer or Malignancies			GI Disorders			Other: _____

●If you answered YES to any of the above, please explain: _____

●Please make us aware of current medical issues including medications, pending surgery, recent injuries, or any other information pertinent to your health: _____

My signature below authorizes the completion of all agreed upon dental services I certify that the above information is complete and accurate.

_____ _____/_____/_____
(Signature) (Date)

We appreciate the confidence in choosing our office. The best compliment is the referral of your friends and neighbors.