1720 Washington Road
Suite 203
Pittsburgh, PA 15241
412.409.4444

New Patient Health History

Patient Biographical Information			
First Name:	Middle Initial:	Last Name:	Nickname:
Birth date:	Age:	Gender:	Social Security #:
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	
Please list the names of any friends or family currently in the practice:			
List any sports, hobbies, or musical instruments played:			
How did you hear about our practice (check all that applies)?			
☐ Community Event	☐ School Visit	☐ Angie's List	☐ Facebook
☐ Google	☐ Yelp	☐ Invisalign Website	☐ Insurance Company
☐ Magazine/Newspaper Advertisement		☐ Family Member/Friend/Neighbor (If so, whom?)	
☐ Dentist/ Dr. (If so, whom?)			

Financial Party Information			
Who is responsible for account?	**Marital Status:** ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated		
Relation: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian ☐ Spouse ☐ Self ☐ Parents ☐ Grandparents ☐ Other		**Relation:** ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian ☐ Spouse ☐ Self ☐ Parents ☐ Grandparents ☐ Other	
Name:	Birthdate:	Name:	Birthdate:
Address: (If different than Patient)		Address: (If different than Patient)	
SS #:		SS #:	
Employer:	Occupation:	Employer:	Occupation:

Orthodontic Coverage		Orthodontic Coverage	
Insurance Co. Name:		Insurance Co. Name:	
Insurance Co. Address:		Insurance Co. Address:	
Ins. Ph #:	Insured's ID #:	Ins. Ph #:	Insured's ID #:
Group # (Plan, Local or Policy #:		Group # (Plan, Local or Policy #:	

Authorization

This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance.

Signature:_____Date: _____

Dental History			
Dentist Name:			
Check-up Frequency:		Last Dental Visit:	
Has the patient had an orthodontic consult or treatment?		If so, when?	
What is the patient's main orthodontic concern?			
Speech problems/therapy?	☐ Yes ☐ No	Brush teeth daily?	☐ Yes ☐ No
Grind or clench teeth?	☐ Yes ☐ No	Floss teeth daily?	☐ Yes ☐ No
Oral habits (thumb/finger habit, lip/nail biting)?	☐ Yes ☐ No	Fluoride treatments?	☐ Yes ☐ No
Injury to face, jaw, teeth, or mouth?	☐ Yes ☐ No	Sleep with mouth open?	☐ Yes ☐ No
Discomfort from teeth or gums?	☐ Yes ☐ No	Snores during sleep?	☐ Yes ☐ No
Pain, tenderness, or noise in either jaw?	☐ Yes ☐ No	Requires premedication?	☐ Yes ☐ No
Frequent headaches?	☐ Yes ☐ No	Any missing or extra permanent teeth?	☐ Yes ☐ No
Neck/shoulder pain?	☐ Yes ☐ No	Apprehensive about dental care?	☐ Yes ☐ No
Frequent sore throats?	☐ Yes ☐ No	Frequently chews gum?	☐ Yes ☐ No
If any of the above dental questions were answered "Yes," please explain:			

Medical History			
Physician Name:	Date of last Physical:	Patient Health:	
Address:	City:	State:	Zip:
List any medications currently being taken by the patient:			
List any drug allergies or sensitivities that the patient may have:			
Rheumatic Fever	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Tuberculosis/Lung Disease	☐ Yes ☐ No	Family History of Cancer	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Received Radiation Treatment	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	Growth Problems	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Endocrine Problems	☐ Yes ☐ No
Heart Attack/Stroke	☐ Yes ☐ No	Hormone Therapy	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Latex/Metal Allergy	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Nervous Disorders	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Bone Disorders/Bone Loss	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Hypertension/High Blood Pressure	☐ Yes ☐ No	Seizures/Epilepsy	☐ Yes ☐ No
Prolonged Bleeding/Transfusion	☐ Yes ☐ No	Handicaps/Disabilities	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Treated for Emotional Problems	☐ Yes ☐ No
Tonsils/Adenoids Removed	☐ Yes ☐ No	Ever Been Hospitalized	☐ Yes ☐ No
If any of the above medical questions were answered "Yes," please explain:			

Patients Under 18			
Height:	Weight:	School:	Grade:
Father/Guardian 1 Name:		Mother/Guardian 2 Name:	
Has patient begun puberty?			☐ Yes ☐ No
If patient is a girl, has menstruation begun?			☐ Yes ☐ No
If patient is a boy, has their voice changed or have facial hair?			☐ Yes ☐ No
Has the patient grown in the past year or has their shoe size changed recently?			☐ Yes ☐ No
Please list the name and birth date of any siblings:			

Airway History			
Patients Age:	**For internal use only:**	☐ Exp	☐ Non-exp
Sex:	Account Number:	☐ Initial	☐ Final
If this patient is under the age of 18 please answer the following questions:			
While sleeping, does your child …			
…snore more than half the time?		☐Yes ☐No ☐ Don't Know	
…always snore?		☐Yes ☐No ☐ Don't Know	
…snore loudly?		☐Yes ☐No ☐ Don't Know	
…have "heavy' or loud breathing?		☐Yes ☐No ☐ Don't Know	
…have trouble breathing, or struggle to breathe?		☐Yes ☐No ☐ Don't Know	
Have you ever seen your child stop breathing during the night?		☐Yes ☐No ☐ Don't Know	
Does your child…			
…tend to breathe through the mouth during the day?		☐Yes ☐No ☐ Don't Know	
…have a dry mouth on waking up in the morning?		☐Yes ☐No ☐ Don't Know	
…occasionally wet the bed?		☐Yes ☐No ☐ Don't Know	
Does your child…			
…wake up feeling *un*-refreshed in the morning?		☐Yes ☐No ☐ Don't Know	
…have problem with sleepiness during the day?		☐Yes ☐No ☐ Don't Know	
Has a teacher or other supervisor commented that your child appears sleepy during the day?		☐Yes ☐No ☐ Don't Know	
Is it hard to wake your child up in the morning?		☐Yes ☐No ☐ Don't Know	
Does your child wake up with headaches in the morning?		☐Yes ☐No ☐ Don't Know	
Did your child stop growing at a normal rate at any time since birth?		☐Yes ☐No ☐ Don't Know	
Is your child overweight?		☐Yes ☐No ☐ Don't Know	
This child often does not seem to listen when spoken to directly.		☐Yes ☐No ☐ Don't Know	
This child often has difficulty organizing tasks and activities.		☐Yes ☐No ☐ Don't Know	
This child is often easily distracted by extraneous stimuli.		☐Yes ☐No ☐ Don't Know	
This child often fidgets with hands or feet or squirms in seat.		☐Yes ☐No ☐ Don't Know	
This child is often "on the go" or often acts as if "driven by a motor."		☐Yes ☐No ☐ Don't Know	
This child often interrupts or intrudes on others (e.g. butts into conversations or games)		☐Yes ☐No ☐ Don't Know	
Have your child's tonsils/adenoids been removed?		☐Yes ☐No ☐ Don't Know	
And if so, when?			

To the best of my knowledge all above information is correct and it is my responsibility to inform the office of any changes in medical history. I also authorize the dental staff to perform the necessary orthodontic services. If Airway History is filled out, I consent to the collection of my child's breathing data along with photos and full orthodontic records for use in scientific research and analysis? If so, please sign below. Thank you.

Parent/Patient Signature:_____Date: _____

I verbally reviewed the medical/dental information above with the patient.

Doctor Signature:_____Date: _____