PATIENT ID # _____

Hawaii Orthodontist
WE MAKE PEOPLE SMILE :)™

We are pleased to welcome you to our office. Please fill out this form as completely as you can.
We look forward to a pleasant and professional relationship with you.

MINOR PATIENT HISTORY FORM Date _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

Nickname _____ Birthdate _____ Age _____

Gender: ☐ MALE ☐ FEMALE School _____ Grade _____

Home Address: Street _____ City _____ State _____ Zip _____

Phone: Mobile _____ Home _____ Work _____

Email _____ SSN # _____

INFORMATION - MOTHER

Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ SSN # _____

Phone: Mobile _____ Home _____ Work _____

Email _____

Employer _____ Occupation _____

Business Address: Street _____ City _____ State _____ Zip _____

INFORMATION - FATHER

Last Name _____ First _____ Middle _____

Birthdate _____ Age _____ SSN # _____

Phone: Mobile _____ Home _____ Work _____

Email _____

Employer _____ Occupation _____

Business Address: Street _____ City _____ State _____ Zip _____

GENERAL INFORMATION

How did you hear about our office? ☐ dentist ☐ family ☐ friend ☐ online ☐ other _____

If referred by someone, whom may we thank? _____

Which office is more convenient for you? ☐ Ala Moana ☐ Kunia

ORTHODONTIC INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of insured _____	Name of insured _____
Name of insurance _____	Name of insurance _____
Group # _____	Group # _____
Subscriber # _____	Subscriber # _____
Effective date _____	Effective date _____

Patient Signature _____ Parent Signature _____

PATIENT ID # _____

PATIENT MEDICAL HISTORY

Physician _____ Phone # _____ Date of last exam _____

Physician Address: Street _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone # _____

Do you have, or have you had any of the following:

☐ Anemia	☐ Rheumatic Fever	☐ Fainting spells / Seizures
☐ Heart Ailments	☐ Blood Diseases	☐ Sinus Trouble
☐ High Blood Pressure	☐ Hepatitis, Jaundice	☐ Rheumatism / Arthritis
☐ Respiratory Disease	☐ HIV / AIDS	☐ Head Injuries
☐ Tuberculosis	☐ Kidney / Liver Disease	☐ Stomach Ulcers
☐ Nervous Disorders	☐ Tumors or Growths	☐ Tonsils removed
☐ Diabetes	☐ Tonsils / Adenoids removed	☐ Epilepsy
☐ Excessive bleeding	☐ Allergies (latex / metal)	☐ Stroke
☐ Osteoporosis	☐ Asthma or Hay Fever	☐ Disabilities
☐ Bone disorder or bone loss	☐ Joint replacement	☐ Pregnant (Women)

Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No _____
Do you use tobacco, alcohol, cocaine or other drugs? ☐ Yes ☐ No _____
Are you under a physician's care now? ☐ Yes ☐ No _____
Are you sensitive or allergic to any drugs? Please list. ☐ Yes ☐ No _____
Are you taking any medications or vitamins? Please list. ☐ Yes ☐ No _____

PATIENT DENTAL HISTORY

Dentist _____ Phone # _____ Date of last exam _____

Dentist Address: Street _____ City _____ State _____ Zip _____

If female, has menstruation started? If so, when? ☐ Yes ☐ No _____
If male, has voice changed or is facial hair present? ☐ Yes ☐ No _____
Have you ever had complications from dental extractions? ☐ Yes ☐ No _____
Do your gums bleed excessively? ☐ Yes ☐ No _____
Do you have cold sores, blisters or swelling on gums/lips/cheeks? ☐ Yes ☐ No _____
Do you suffer from headaches? If yes, how often? ☐ Yes ☐ No _____
Any difficulty breathing through your nose or difficulty swallowing? ☐ Yes ☐ No _____
Any pain or clicking in your jaw joint? ☐ Yes ☐ No _____
Are you aware of clenching or grinding of your teeth? ☐ Yes ☐ No _____
Do you have any speech problems? ☐ Yes ☐ No _____
Any accidents to your jaws, face or teeth? ☐ Yes ☐ No _____
Have you had previous orthodontic treatment? If so, with whom? ☐ Yes ☐ No _____
Has anyone else in your family had orthodontic treatment? ☐ Yes ☐ No
If yes, please list: _____

What is the patient's/parent's main orthodontic concern?

_____

Is there anything else in your dental/medical history we need to know when considering your treatment?

_____

I, the undersigned, believe the above information to be complete and accurate. If there are any changes to this history in the future I will inform the Hawaii Orthodontist office.

Parent Signature _____ Date _____

Form Updates _____ Office Initial _____ Date _____

Form Updates _____ Office Initial _____ Date _____

Form Updates _____ Office Initial _____ Date _____