HEALTH HISTORY QUESTIONNAIRE

Scott Ralph, DDS MS, Orthodontist

We have enclosed this medical /dental history questionnaire as one measure of collecting important information necessary in providing the highest level of care. Be sure to answer EVERY question.

Patient Information

Patient First Name _____ Middle Initial _____ Last Name _____ I Prefer To Be Called _____

Gender: □ Male □ Female Social Security Number _____ Birthdate _____ Age _____

Patient is (check all that apply): □ Child □ Adult □ Single □ Married □ Separated □ Divorced □ Widowed

If patient is a minor, parent or guardian name _____

Patient Address _____ City _____ State _____ Zip _____

Preferred Phone #_____ Home # _____ Work # _____ Cell # _____

I would like text message appointment reminders: □ Yes □ No If yes, cell provider name is required. _____

Patient Email Address: _____ Patient School _____ Grade _____

Patient Occupation _____ Employer _____ Patient's General Dentist _____

Preferred Office: □ Liberty Lake □ South Hill Have you seen another orthodontist? □ Yes □ No Who? _____

Any treatment provided? □ Yes □ No Other family members seen by us _____

How did you hear about our office and whom may we thank for referring you? _____

What would you like Dr. Ralph to address? _____

Responsible Party Information

Adult Patients: Complete this section for yourself and your spouse. Parents: Complete section with parental information.

Relation 1

Relationship to patient (check all that apply): □Self □Spouse □Mother □Father □Cust Parent □Non-Cust Parent □Other _____

Full Name _____ Birthdate _____

Residence Address _____ City _____ State ____ Zip _____

Mailing Address _____ City _____ State ____ Zip _____

Home Phone _____ Work # _____ Cell # _____

I would like text message appointment reminders: □ Yes □ No If yes, cell provider name is required. _____

Email Address: _____ Social Security Number _____

Occupation _____ Employer _____

Spouse's Name _____ Relationship to patient _____

Relation 2

Relationship to patient (check all that apply): □Self □Spouse □Mother □Father □Cust Parent □Non-Cust Parent □Other _____

Full Name _____ Birthdate _____

Residence Address _____ City _____ State ____ Zip _____

Mailing Address _____ City _____ State ____ Zip _____

Home Phone _____ Work # _____ Cell # _____

I would like text message appointment reminders: □ Yes □ No If yes, cell provider name is required. _____

Email Address: _____ Social Security Number _____

Occupation _____ Employer _____

Spouse's Name _____ Relationship to patient _____

Medical History

Please indicate by placing an X if you have had any of the following problems. If yes please specify in the area provided.

- ☐ Head/neck
- ☐ Nerve
- ☐ Eye
- ☐ Ear
- ☐ Nose/sinus
- ☐ Throat
- ☐ Breathing
- ☐ Back/shoulders/extremity
- ☐ Bone
- ☐ Breast
- ☐ Heart
- ☐ Urinary
- ☐ Stomach/intestine
- ☐ Endocrine

_____

- ☐ Liver
- ☐ Kidney
- ☐ Blood
- ☐ Skin
- ☐ Psychological
- ☐ Drug reactions
- ☐ Anesthetic reactions
- ☐ Are you pregnant or think you may be? _____
- ☐ Do you anticipate becoming pregnant? _____
- ☐ Phen-Fen? When? How long?

_____

- ☐ Bisphosphonate Meds? When? How long?

_____

Chronic Disease

- ☐ Diabetes
- ☐ Cancer
- ☐ Hepatitis ☐A ☐B ☐C
- ☐ HIV
- ☐ AIDS
- ☐ Tuberculosis
- ☐ Tonsilitis
- ☐ Heart surgery

_____

- ☐ Other surgery

_____

- ☐ Serious injury

_____

Family history of chronic disease *(Please List)*

_____

_____

Habits

- ☐ Smoking ☐ Alcohol
- ☐ Over eating ☐ Caffeine

Medications

Presently taking:

_____

_____

_____

Allergic Reactions

- ☐ Latex
- ☐ Metals
- ☐ Foods
- ☐ Anesthetic
- ☐ Anti-bacterial drugs
- ☐ Pain medication
- ☐ Other (describe)

_____

Dental History

- ☐ Tooth injury
- ☐ Oral disease
- ☐ Jaw injury

- ☐ Teeth grinding
  - ☐ During the day
  - ☐ When sleeping

- ☐ Teeth clenching
  - ☐ During the day
  - ☐ When sleeping

- ☐ Bleeding gums
- ☐ Jaw locking
  - ☐ When open ☐ When closed

- ☐ Jaw joint pain
  - ☐ Right
    - ☐ Constant ☐Periodic
  - ☐ Left
    - ☐ Constant ☐Periodic

- ☐ Jaw joint noise
  - ☐ Right
    - ☐ Click ☐ Popping ☐Grating
  - ☐ Left
    - ☐ Click ☐ Popping ☐Grating

- ☐ Periodontal (gum treatment)
- ☐ Orthodontic treatment
- ☐ Endodontics (root canal)

Date of last visit to dentist _____

- ☐ Oral surgery treatment
- ☐ Prosthodontics (crown/bridge)

Who provided treatment?

_____

Please cover any additional problems or concerns not yet covered and expand on any previous questions as needed.

_____

_____

_____

_____

Thank you for choosing our office for your orthodontic consultation. Most orthodontic appointments are scheduled during school or work hours. We respect your need to be treated promptly, and for this reason, we are proud of the fact that we receive our patients at their appointment times. We make a sincere effort to schedule convenient appointment times for our patients. However, it is necessary to alternate morning and afternoon appointments, particularly during the school year.

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

_____ _____

Signature Of Person Filling Out This Health History — Date Form Completed

_____ _____ _____

Signature of Examining Doctor — Signature of Treatment Coordinator — Date Reviewed

Please complete thoroughly and write legibly
so that we may best assist you.

PRIMARY DENTAL INSURANCE INFORMATION

Name of Patient: _____ Date of Birth: _____
Name of Insured: _____ Date of Birth: _____
Street Name/Number of Insured: _____
City, State, ZIP of Insured: _____
Social Security # of Insured: _____ Telephone # of Insured: _____
Policy or Group # of Insured: _____ ID # of Insured: _____
Employer Name: _____
Name of Insurance Company: _____
Insurance Company Address: _____
Insurance Company Telephone #: _____

OFFICE USE ONLY
Date: _____ Contact Person: _____
Maximum Coverage: $_____ Lifetime ☐ or Yearly ☐ paid at_____%
Deductible: $_____ Age Limit:_____ Other Limitations:_____
Amount Used to Date:_____ Pre-Auth Required? Y N
Benefit is Paid: Monthly Quarterly Biannual Annual Other Benefit Pd? Prov Sub
Bill: Auto Manual Payor ID#: _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Patient: _____ Date of Birth: _____
Name of Insured: _____ Date of Birth: _____
Street Name/Number of Insured: _____
City, State, ZIP of Insured: _____
Social Security # of Insured: _____ Telephone # of Insured: _____
Policy or Group # of Insured: _____ ID # of Insured: _____
Employer Name: _____
Name of Insurance Company: _____
Insurance Company Address: _____
Insurance Company Telephone #: _____

OFFICE USE ONLY
Date: _____ Contact Person: _____
Maximum Coverage: $_____ Lifetime ☐ or Yearly ☐ paid at_____%
Deductible: $_____ Age Limit:_____ Other Limitations:_____
Amount Used to Date:_____ Pre-Auth Required? Y N
Benefit is Paid: Monthly Quarterly Biannual Annual Other Benefit Pd? Prov Sub
Bill: Auto Manual Payor ID#: _____

I authorize release of information relating to orthodontic treatment. I hereby authorize payment directly to the above named orthodontist, otherwise payable to me. If the payment is made to the subscriber, I understand that it is my responsibility to remit payment to the office. I understand that if the insurance does not cover expenses, I am responsible per contract for the amount owing Dr. Scott Ralph.

_____ _____
Signed (Patient or Responsible Party) Date

_____ _____
Signed (Insured) Date