Trammell Orthodontics
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TRAMMELLORTHODONTICS.COM

Health History Form

Patient Information The following information is requested so that we can get to know you and communicate most effectively.

Today's Date: _____/_____/_____

Patient's Full Name:_____ Patient Nickname:_____

Age:_____ DOB:_____/_____/_____ Sex:_____ School_____

Address_____ Patient's Home Phone( ) _____ - _____

City/State/Zip_____ Patient's Cell Phone ( ) _____ - _____

Patient's Email_____ Whom may we thank for referring you? _____

Has anyone else in your family been treated by Dr. Trammell? ☐ Yes ☐ No If yes, who?_____

Hobbies & Groups:

☐ Basketball (Team)_____
☐ Baseball (Team)_____
☐ Soccer (Team)_____
☐ Football (Team)_____
☐ Wrestling (Team)_____
☐ Cross Country (Team)_____
☐ Lacrosse (Team)_____
☐ Volleyball (Team)_____
☐ Swimming (Team)_____
☐ Cheerleading (Team)_____
☐ Tennis (Team)_____
☐ Golf (Team)_____
☐ Karate/Judo (Team)_____
☐ Dance (Team/Studio)_____

☐ Reading_____ Participate in OBOB? ☐ Yes ☐ No
☐ Photography _____
☐ Art (type) _____
☐ Theater (type) _____
Where have you performed? _____
☐ Instruments Played _____
Do you play in a band/group? _____
☐ Singing _____
Do you sing in a choir/group? _____
☐ Writing _____
☐ Video Games (favorite) _____
☐ Boy/Girl Scouts (Troop #) _____ Have to attended a badge-earning tour at our office? ☐ Yes ☐ No
☐ Other _____

Parent Information The following information is requested so that we can communicate properly with the people involved with your child's treatment.

Parent #1: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

DOB:____/____/_____Relationship to Patient: _____

Address, if different from patient:_____

_____

Length at residence: _____ years _____ months

Home Phone, if different from patient:( ) _____ - _____

Parent #1's Email_____

Cell Phone: ( ) _____ - _____ Prefer ☐ Call ☐ Text

Occupation _____ Employer _____

How Long _____ Work Phone: ( ) _____ - _____

Parent #2: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

DOB:____/____/____Relationship to Patient: _____

Address, if different from patient:_____

_____

Length at residence: _____ years _____ months

Home Phone, if different from patient:( ) _____ - _____

Parent #2's Email_____

Cell Phone: ( ) _____ - _____ Prefer ☐ Call ☐ Text

Occupation _____ Employer_____

How Long _____ Work Phone: ( ) _____ - _____

With whom does the patient live? (custodial parent) _____

Names/Ages of Siblings: _____

Person Responsible for account: ☐ Parent #1 ☐ Parent #2 ☐ Someone Else (Relation to Patient):_____

If someone else will be financially responsible for this account, please provide their information:

Name: _____ Phone: ( ) _____ - _____ Email: _____

Insurance Information Complete the following section so that we can estimate potential orthodontic insurance benefits for your family

Policy Holder #1: _____
DOB:___/___/____ Employer:_____
SS# or Member ID:_____
Insurance Co:_____ Group #_____
Insurance Phone :( ) _____ - _____
Insurance Address:_____
_____

Policy Holder #2: _____
DOB:___/___/____ Employer:_____
SS# or Member ID:_____
Insurance Co:_____ Group #_____
Insurance Phone :( ) _____ - _____
Insurance Address:_____
_____

Medical History

Physician_____ Last Visit ____/____/____
Patient's Height_____ Weight_____

☐ Yes ☐ No Unusual Reaction to Medication
☐ Yes ☐ No Injury to Head, Face or Mouth
☐ Yes ☐ No Surgery, Serious Illness, or Hospitalization
☐ Yes ☐ No Tonsils or Adenoids Removed
☐ Yes ☐ No Currently Pregnant or Possibly Pregnant
☐ Yes ☐ No Born with any Congenital Problems
☐ Yes ☐ No Ever Diagnosed with a Heart Murmur
☐ Yes ☐ No Dr. Recommends Pre-Dental Antibiotics
☐ Yes ☐ No Any Current Medical Problems
☐ Yes ☐ No Any Allergies (food, medication, etc)
☐ Yes ☐ No Currently Taking any Medications or Drugs

Please explain any "Yes" Answers: _____
_____
_____

Has the patient ever been diagnosed or treated for any of the following? Circle all that apply.

Diabetes	Fainting/Dizziness	Arthritis
Anemia	Heart Condition	Kidney Problem
Liver Problem	Breathing Trouble	Bone Disease
Epilepsy	Endocrine Problem	Hepatitis
Pneumonia	Rheumatic Fever	AIDS or HIV
Asthma	Tuberculosis	Ulcers
Cancer	Low/High Blood Pressure	Joint Replacement
Asperger's	Communication Disability	Emotional Problems
Learning Disability	Prolonged Bleeding	Cerebral Palsy
Bleeding Disorder	Recurrent Pain	Multiple Sclerosis
Nervous Disorder	Growth Disorder	Seasonal Allergies

Dental History

Dentist_____ Last Visit _____/_____/_____
Main Orthodontic Concern: _____

☐ Yes ☐ No Currently Undergoing any Dental Treatment
☐ Yes ☐ No Seen a Periodontist or Endodontist
☐ Yes ☐ No Seen an Oral Surgeon / Had Extractions
☐ Yes ☐ No Had any Injured or Broken Teeth
☐ Yes ☐ No Any Missing or Extra Adult Teeth
☐ Yes ☐ No Difficulty Eating, Speaking, or Swallowing
☐ Yes ☐ No Any Dental or Facial Pain
☐ Yes ☐ No Jaw Joint Pain, Popping, or Noises
☐ Yes ☐ No Jaw Ever Locked Open or Closed
☐ Yes ☐ No Tooth Grinding or Clenching
☐ Yes ☐ No Normally Breathes Through Mouth / Lips Apart
☐ Yes ☐ No Any Swellings / Growths on Mouth or Face
☐ Yes ☐ No Temperature-Sensitive Teeth or Bleeding Gums
☐ Yes ☐ No Patient is Hesitant or Opposed to Treatment
☐ Yes ☐ No Has Patient Had Previous Ortho Treatment
☐ Yes ☐ No Has Patient Had Previous Ortho Consultation
☐ Yes ☐ No Any Other Family Members Had Ortho Treatment

Please explain any "Yes" Answers: _____
_____
_____
_____
_____

Any other Information we should have: _____
_____
_____

Signature (Parent/Guardian if patient is a minor)_____ **Date:** _____/_____/_____