SHENANDOAH VALLEY
ORTHODONTICS

1705 Amherst St., Suite 103
Winchester, VA 22601
(540) 667-9662

920 N. Shenandoah Ave., Suite 201
Front Royal, VA 22630
(540) 635-1695

HEALTH HISTORY FORM

Patient Information

Name		Nickname	
Address			
City	State	Zip	
Date of Birth		Male ◯ Female ◯	Age
Cell Phone		Cell Phone Carrier	
Email			
Names of family members currently at SVO			
How did you hear about our practice?			
What school do you attend (if student)?			Grade

Responsible Party

If same as above, check here ☐ and skip this section.

Name			
Address			
City	State	Zip	
Cell Phone		Cell Phone Carrier	

Dental Insurance

Does your insurance cover orthodontic treatment? Yes ◯ No ◯

Policy Holders Name		Employer	
Address			
City	State	Zip	
Date of Birth		ID #	
Insurance Company		Group #	
Insurance Company Address			
City	State	Zip	

Patient Dental History

Dentist Name	Date of Last Dental Visit
Check-up Frequency Per Year 1 ◯ 2 ◯ Less than once per year ◯	
Has the patient had previous orthodontic treatment? Yes ◯ No ◯	
What is your main orthodontic concern?	

Please select YES for any conditions the patient currently has or has had previously.

	YES	NO		YES	NO		YES	NO
Speech problems/therapy?	◯	◯	Discomfort from teeth or gums?	◯	◯	Frequent sore throats?	◯	◯
Grind or clench teeth?	◯	◯	Pain, tenderness or noise in either jaw?	◯	◯	Fluoride treatments?	◯	◯
Oral Habits (thumb sucking, lip/nail biting)?	◯	◯	Frequent headaches?	◯	◯	Snores during sleep?	◯	◯
Injury to face, jaw, teeth or mouth?	◯	◯	Neck/shoulder pain?	◯	◯	Requires premedication?	◯	◯
Any missing or extra permanent teeth?	◯	◯						

If any of the above questions were marked YES, please explain.

Patients Under 18 Skip this section if it does not apply

Height	Weight
Father/Guardian Name	Mother/Guardian Name
Has the patient begun puberty? Yes ◯ No ◯	If female, has menstruation begun? Yes ◯ No ◯
If male, has their voice changed or have facial hair? Yes ◯ No ◯	
In the past year, has the patient grown or changed shoe size? Yes ◯ No ◯	
Patient's Interest In Treatment Interested ◯ Not Interested ◯ Indifferent ◯	
Has either biological parent ever had orthodontic treatment? Yes ◯ No ◯	

Medical History

Physician Name		Date of Last Physical
Address		
City	State	Zip
Primary Phone		
List any medication currently being taken by the patient.		
List any drug allergies or sensitivities that the patient may have.		

Please select YES for any conditions the patient currently has or has had previously.

	YES	NO
Rheumatic Fever	◯	◯
Tuberculosis/Lung Disease	◯	◯
Kidney Disease	◯	◯
Heart Disease	◯	◯
Heart Murmur	◯	◯
Hypertension/High Blood Pressure	◯	◯
Anemia	◯	◯
Hepatitis	◯	◯
Cancer	◯	◯
Received Radiation Treatment	◯	◯
Endocrine Problems	◯	◯

	YES	NO
Latex/Metal Allergy	◯	◯
Bone Disorders/Bone Loss	◯	◯
Seizures/Epilepsy	◯	◯
Asthma	◯	◯
Treated for Emotional Problems	◯	◯
Pneumonia	◯	◯
Liver Disease	◯	◯
Heart Attack/Stroke	◯	◯
Congenital Heart Defect	◯	◯
Hemophilia	◯	◯
Prolonged Bleeding/Transfusion	◯	◯

	YES	NO
HIV/AIDS	◯	◯
Tonsils/Adenoids Removed	◯	◯
Family History of Cancer	◯	◯
Growth Problems	◯	◯
Hormone Therapy	◯	◯
Nervous Disorders	◯	◯
Diabetes	◯	◯
Handicaps/Disabilities	◯	◯
Arthritis	◯	◯
Ever Been Hospitalized	◯	◯

If any of the above questions were marked YES, please explain.

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of their form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I grant permission to the doctors to use my clinical photographs in scientific journals or magazines, or in lecture presentations.

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_____ _____

Patient or Parent/Guardian Signature Date

SUBMIT