Stan R. Heiner, DDS, Inc.
Practice Limited to Orthodontics

HEALTH HISTORY

Patient Name____Birthdate___________________________

Address____City______________________Zip____________________

Home Phone____Work Phone_____________________________________

Cell Phone____Email Address___________________________________

Dentist____Dentist's Phone__________________________________

Physician____Physician's Phone________________________________

PLEASE CHECK ANY OF THE FOLLOWING CONCERNS:

____Chewing
____Swallowing
____Crowding
____Spacing
____Overbite
____Open bite
____Gummy Smile
____Tongue Habits
____Buck teeth
____Missing teeth
____Receeded jaw
____Protruding jaw
____Jaw pain
____Jaw/Joint clicking
____Jaw popping
____Crossbite
____Gum disease
____Gum recession
____Protrusion
____Thumb/finger habit
____Neck pain
____Facial pain
____Teeth grinding
____Headaches
____Irregular facial proportions
____Ringing in ears
____Stuffines in ears
____Irregularly shaped teeth.
____Small mouth

Have any of these concerns been discussed with a health care professional?____

____

Do other family members have similar conditions?_____________________Were they corrected?______________________

____

In the case of missing teeth, what treatment options are of interest to you?____

____

Describe any unusual dental experiences:____

____

____

Do any speech problems exist?____

If so, has a specialist been consulted?____

Please specify your reasons for seeking an orthodontic consultation:____

____

Has another orthodontic opinion been received?____

Has previous orthodontic treatment been rendered?__________If so, what and when?________________________________

____

____

What do you expect from orthodontic treatment?____

____

____

PLEASE CHECK ANY CONDITIONS WHICH HAVE BEEN DIAGNOSED AND/OR TREATED:

____Aids or HIV	____Blood disease	____Epilepsy	____Hearing disorder	____Sleep disorders
____Allergies	____Bone disorders	____Heart disease	____Kidney disease	____Diabetes
____Asthma	____Cancer	____Hepatitis	____Dizziness	____Trauma to teeth, face, head or jaw(s)
____Arteriosclerosis	____Autoimmune disorder	____Endocrine problems	____Emotional problems	____OTHER
____High blood pressure	____Low blood pressure	____Rheumatic fever	____Airway obstruction (tonsils/adenoids)	

Please indicate if there are any known metal allergies____

If any of the above are checked, please complete the following:

Doctor(s) who treated the condition(s):____

Date(s) affected:____

Extent of the condition(s):____

Current status of the condition:____

____

Please list any medications (and dosages) currently being taken:____

____

Identify medications, antibiotics, pain pills, foods or other substances which cause an allergic reaction:__________________

____

Is tobacco used? If so, in what form and how often?____

Are there any medical, dental or surgical problems not covered above?_______________________________________

____

Signature____Date_____________________________________

FOR FEMALE PATIENTS ONLY:
Are you pregnant?__________________Is it possible that you might be pregnant?______________________

If either of the above questions were answered affirmatively, we must have clearance from your physician or OB/GYN prior to taking x-rays or beginning orthodontic treatment. Initials___________Date___________