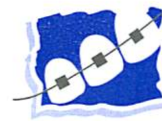
PATIENT INFORMATION
& HEALTH HISTORY



SIMISTER ORTHODONTICS

Jeffrey R. Simister, DDS, MSD, PC | Bradley G. Simister, DDS, MSD, PC

Responsible Party Information

Name ______________________ Marital Status ______________

Mailing Address: ______________________
Street City/State Zip Code

How long at this address ____________ Home Phone ____________ Work Phone ____________

Previous Address (if less than 3 years): ______________________
Street City/State Zip Code

Email Address ______________________ Cell Phone ______________

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________

Employer ____________ Occupation ____________ Years Employed ____________

Spouse's Name ______________________ Relationship to Patient ____________

Employer ____________ Occupation ____________ Years Employed ____________

Social Security # ____________ Birthdate ____________ Work Phone ____________

Patient Information

Patient's Name ______________________

Address ______________________
Street City/State Zip Code

Home Phone ____________ Birthdate ____________ Social Security # ____________

If patient is a minor, give parent or guardian's name ______________________

Whom may we thank for referring you to our office? ______________________

Insurance Information

Policy Holder's Name ____________ Birthdate ____________ Social Security # ____________

Primary Insurance Company ____________ Group # ____________ Member ID # ____________

Insurance Co. Address: ______________________ Insurance Co. Phone ____________
Street City/State Zip Code

Policy Holder's Employer ______________________

Policy Holder's Name ____________ Birthdate ____________ Social Security # ____________

Secondary Insurance Company ____________ Group # ____________ Member ID # ____________

Insurance Co. Address: ______________________ Insurance Co. Phone ____________
Street City/State Zip Code

Policy Holder's Employer ______________________

I authorize the release of my information relating to any insurance claim, to my insurance company. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize payment directly to the above named orthodontist or the group insurance benefits otherwise payable to me.

Signature *(Parent's signature if minor)* ______________________ Date ____________

Updates *(Date & Initial)* ______________________

Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ______________________________

Phone ______________________ Relationship ______________________

Medical History

General Dentist ______________________ Last Cleaning ______________________

Is patient in good health? ______________________ ☐ Yes ☐ No

Does patient have any history of major illness? ______________________ ☐ Yes ☐ No

AIDS ☐	Anemia ☐	Prolonged Bleeding ☐
Diabetes ☐	Epilepsy ☐	Fainting or Dizziness ☐
Pneumonia ☐	Asthma ☐	Nervous Disorders ☐
Heart Trouble ☐	Kidney Involvement ☐	Hepatitis ☐
Rheumatic Fever ☐	Tuberculosis ☐	Endocrine Problems ☐
Bone Disorders ☐		

Does patient have tendency to: Colds? ☐ Sore Throats? ☐ Ear Infections? ☐

Have Tonsils and Adenoids been removed? What age? ______________________ ☐ Yes ☐ No

List any drugs or medications currently being taken. Give reasons ______________________

____

List any allergies or drug sensitivity ______________________

Has the patient reached puberty? GIRLS - Has she started menstruation? ☐ Yes ☐ No

BOYS - Has his voice changed? ☐ Yes ☐ No

Height ______________ Weight ______________

Dental History

Has there been any injuries to the face, mouth or teeth? ______________ ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? Until what age? ______________ ☐ Yes ☐ No

Does the patient have any speech problems? ______________ ☐ Yes ☐ No

Is the patient a mouth breather? While awake? ______________ ☐ Yes ☐ No

While asleep? ______________ ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? ______________ ☐ Yes ☐ No

Has an orthodontist been consulted previously? ______________ ☐ Yes ☐ No

Has either parent had orthodontic treatment? ______________ ☐ Yes ☐ No

List any musical instruments played ______________________

Reason for consultation ______________________