Dr. Eckler • Dr. Black • Dr. Leung
ORTHODONTISTS
"SmileSolutions"

HEALTH HISTORY

Patients Name:_________________________________ Date of Birth:_____/_____/ _____ Male ☐ Female ☐
MM DD YYYY

Person(s) responsible for the account:___________________________ Relation to patient: ____________________

Dentist's Name: *(first and last)*______________________________ Date of last check-up: _________________________

Any outstanding dental work YES ☐ NO ☐ Please explain any dental work still to be done:_________________________

Have you ever had any orthodontic consultations or treatment? YES ☐ NO ☐ If yes, please explain: ___________________

If yes, please describe: ____

Physician's name: *(first and last)*____ Telephone #:______________________

Is the patient healthy? YES ☐ NO ☐ If no, please describe medical concerns: ___________________________________

____

Does the patient have any history of the following (please check all that apply or NONE APPLY):

☐ Joint (TMJ)
☐ Missing Teeth
☐ Nail Biting
☐ Thumb/Finger Habit
☐ Gum Disease
☐ Trauma to Any Teeth
☐ Tongue Thrusting
☐ Cavities
☐ Other
☐ NONE APPLY

Are any of the following applicable to the patient (please answer all questions): **(circle YES or NO)**

Are you currently healthy	☐ YES	☐ NO	Any current health concerns	☐ YES	☐ NO
Past Medical Problems (list below)	☐ YES	☐ NO	Autism	☐ YES	☐ NO
Past Hospitalizations list below	☐ YES	☐ NO	Pregnant/Breast Feeding	☐ YES	☐ NO
Any heart conditions or blood pressure problems	☐ YES	☐ NO	Bleeding problems	☐ YES	☐ NO
Taking any medications (list below)	☐ YES	☐ NO	Medications Required Prior to Dental Visits	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Use of puffer yes ☐ no ☐ frequency ____________________		
Allergies	☐ YES	☐ NO	Immuno-Compromising disease/disorder	☐ YES	☐ NO
LATEX ALLERGY	☐ YES	☐ NO	Other:		

Date of last physical exam with medical doctor:________________(MM / YYYY)
Other medical concerns yes/no (if yes explain)____
Medication List / Past Hospitalizations____
____

I give permission for Drs. Eckler, Black & Leung's office to communicate with me by mail, email, telephone and text Yes ☐ No ☐

I give permission for Drs. Eckler, Black & Leung's office to communicate with healthcare providers regarding but not limited to personal health information by mail, email, text and telephone. Yes ☐ No ☐

I give permission for Drs. Eckler, Black & Leung's office to use my images for patient education and office TV screen Yes ☐ No ☐

As an Orthodontic Specialist we do not check for any cavities or do cleanings. Please return to your family dentist every 3 to 6 months for cleanings and check-ups. By checking this box I understand the preceding information ☐

Filled out by:_________________________ Signature: ____________________________________ Date:___________

Orthodontist's Signature :____ Date:_________________________

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