HOYBJERG FAMILY ORTHODONTICS

Office:_____ Date:_____

Patient Info

Name: _____
first mi last

SS No: _____

Email: _____

Address: _____

City:State: _____ Zip:____ _____

H. Phone: _____ W. Phone: _____

Birthday: _____ Sex: _____

Other Children: _____ Birthday: _____

Other Children: _____ Birthday: _____

Other Children: _____ Birthday: _____

Dentist: _____

Dentist's Phone: _____

Dentist's Address: _____

_____

Emergency Name: _____

Emergency Phone: _____

Who may we thank for referring you?

Advertisement: TV_____ Radio _____ Coupon _____

Newspaper/Magazine: _____

Friend: _____

Insurance Co.: _____

1st Responsible Party Info

(Person responsible for payment on account)

❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Other

Name: _____
first mi last

SS No: _____

Email: _____

Address: _____

City: _____ State: ____ Zip:_____

H. Phone: _____ W. Phone: _____

Birthday: _____ Age: _____ Sex: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State:____Zip:_____

DENTAL INSURANCE COMPANY

Orthodontic Coverage? ☐Y ☐N

Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____

Group No: _____ Local / Union No: _____

2nd Responsible Party Info

(Person responsible for payment on account)

❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Other

Name: _____
first mi last

SS No: _____

Email: _____

Address: _____

City: _____ State: ___ Zip: _____

H. Phone:_____ W. Phone:_____

Birthday:_____ Age: ____ Sex: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____State:____ Zip:_____

DENTAL INSURANCE COMPANY

Orthodontic Coverage? ☐Y ☐N

Name: _____

Address:_____

City: _____ State:____ Zip: _____

Phone: _____

Group No: _____ Local / Union No: _____

Sacramento
9550 Micron Ave. Suite A
916-381-7171

Placerville
4363 Golden Center Dr.
530-626-3000

Roseville
1253 Pleasant Grove Blvd. #190
916-771-4884

Modesto
1212 12th Street
209-238-9700

El Dorado Hills
4517 Serrano Parkway #102
916-573-3388

Health Data Sheet

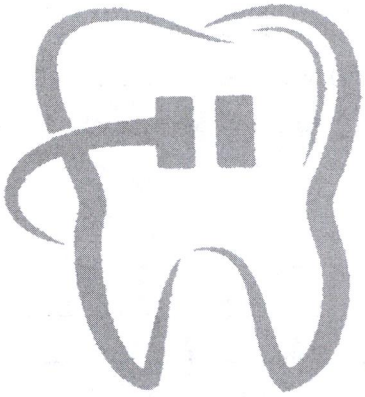
Health History Form Updated

Int. _____
Date_____

Int. _____
Date_____

Int. _____
Date_____

Int. _____
Date_____



Medical History

	YES	NO
Any heart disease:		
Any respiratory disease:		
Any blood disease:		
Any liver disease:		
Any thyroid disease:		
Any kidney disease:		
H.I.V. positive:		
Any venereal disease:		
Any intestinal disease:		
Any bone disease:		
Any nervous/emotional problems:		
Any high or low blood pressure:		
Any endocrine problems:		
Any problem with wounds healing:		
Rheumatic/yellow/scarlet fever:		
Acquired Immune Deficiency Syndrome:		
Is patient under medical care:		
Rheumatism or arthritis:		
Is patient taking any medications:		
A history of fainting or dizziness:		
Headaches:		
Does patient have a drug addiction:		
Is patient pregnant at this time:		
Measles/mumps/chicken pox:		
Does patient smoke:		
Is the patient in good health:		
Is height and weight normal for age:		
Has patient ever had fever blisters:		
Has patient had a physical this year:		
Has patient reached puberty:		
Heart murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		
Asthma or hay fever:		
Tuberculosis:		
Had any broken bones:		
Prolonged bleeding:		
Yellow jaundice:		
Radiation therapy:		
Chemical therapy:		
Blood transfusions:		
Is the patient allergic to anything:		

If so, what:

_____

List any medications taken in last 90 days:

_____

_____

Are you aware of any other disease, condition, or problem not listed above that we should know about?
If yes, what:

_____

_____

_____

Dental History

	YES	NO
Has the mouth, face or teeth been injured by a fall or accident:		

If so, when: _____

Has the patient seen a general dentist in the last year:		
Any pain, clicking or discomfort in or near the ears:		
Is the patient experiencing TMJ problems:		
Have you been informed of missing or extra permanent teeth:		
Are you aware of any "gum" problems:		
Has a physician or dentist advised antibiotics before a dental exam:		
Have the patient's tonsils or adenoids been removed:		
Do you feel the patient can benefit from orthodontic treatment:		
Is the patient happy with their "SMILE":		
Does the patient want to improve their "SMILE" and "BITE":		
Would the patient mind wearing "BRACES":		

Does the patient have or ever had any of the following habits

Cheek, tongue or lip chewing:		
Thumb sucking:		
Mouth breathing:		
Finger nail biting:		
Clenching teeth:		
Tongue thrusting:		
Grinding teeth:		
Speech problems:		

Orthodontic treatment history

Has the patient been examined by an orthodontist before:		
Have other family members had orthodontic treatment:		
If yes, were you happy with the results:		

If no, why:

_____

In your own words what is the orthodontic problem:

_____

What would you like the orthodontic treatment to accomplish:

_____

Signatures

_____
patient date

_____
responsible party relationship to patient date

_____
doctor date

_____
office witness date