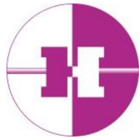
Dr. Frank R. Helm



New Patient Information

Patient Information

Date ___________________________

Patient's Legal Name ____ Nickname ___________________________________

Address ____

Birth Date ____/____/____ Age _________ Sex _______

Phone: Cell ______________________ Ok to text ___ Home __________________ Email _____________________________

School: ____ Grade: _______

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

General Dentist: ____ City _________________________________

Relatives in treatment at our office: Name(s) ____

Chief Concern: ____

Responsible Party Information

Guardian #1 (or Self): Name ____

Address: ____

Address (if less than 3 yrs): ____

Phone: Cell ______________________ Ok to text ____ Home ____________________ Work _____________________

Address: ____

Employer: ____ Occupation: _________________________________

Guardian #2 (or Spouse): Name ____

Address: ____

Address (if less than 3 yrs): ____

Employer: ____ Occupation: _________________________________

Person financially responsible for this account: ____ Phone: _________________________

Orthodontic Insurance Information

Primary Insurance

Insured's Name: ____ Birth Date _____/_____/_____ SSN _____ - ______ - _______

Insurance Company: ________________________________ Group No.: ________________Employer:_____________________________

Insurance Co Address: ____ Phone: _______________________

Do you have dual coverage? ☐ Yes ☐ No

Secondary Insurance

Insured's Name: ____ Birth Date _____/_____/_____ SSN _____ - ______ - _______

Insurance Company: ________________________________ Group No.: ________________Employer:_____________________________

Insurance Co Address: ____ Phone: _______________________

Emergency Information

Name of nearest relative not living with you ____

Complete Address ____ Phone ________________________

TURNOVER

Medical History

Is patient in Good health? ____ ☐ Yes ☐ No

Name and address of Physician: ____

Have you had any serious illness or operation? ☐ Yes ☐ No

If yes, please explain:

____

Have you been hospitalized or had serious illness within the past five years? ☐ Yes ☐ No

If yes, please explain:

ASTHMA ☐ Yes ☐ No CANCER ☐ Yes ☐ No HIGH BLOOD PRESSURE ☐ Yes ☐ No

DIABETES ☐ Yes ☐ No ANEMIA ☐ Yes ☐ No PROLONGED BLEEDING ☐ Yes ☐ No

PNEUMONIA ☐ Yes ☐ No EPILEPSY ☐ Yes ☐ No FAINTING OR DIZZINESS ☐ Yes ☐ No

HEART TROUBLE ☐ Yes ☐ No NERVOUS DISORDER ☐ Yes ☐ No LIVER INVOLVEMENT ☐ Yes ☐ No

RHEUMATIC FEVER ☐ Yes ☐ No TUBERCULOSIS ☐ Yes ☐ No KIDNEY INVOLVEMENT ☐ Yes ☐ No

BONE DISORDERS ☐ Yes ☐ No TMJ/TMD SYMPTOMS ☐ Yes ☐ No ENDOCRINE PROBLEMS ☐ Yes ☐ No

HEPATITIS ☐ Yes ☐ No AIDS/HIV ☐ Yes ☐ No VENEREAL DISEASE ☐ Yes ☐ No

Have tonsils and adenoids been removed? What age? ____________________________ ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Yes ☐ No Aspirin / Ibuprofen ☐ Yes ☐ No Penicillin ☐ Yes ☐ No Latex, Metal, Plastic

☐ Yes ☐ No Sulfa Drugs / Sulfities / Sulfides ☐ Yes ☐ No Codeine ☐ Yes ☐ No Local Anesthetics

Other ____

____

Please list all medications you are currently taking?

____

____

____

Dental History

Have there been injuries to the face, mouth, or teeth? _____________________________ ☐ Yes ☐ No

Has the patient ever sucked a thumb or finger? Until what age? ______________________ ☐ Yes ☐ No

Does the patient have any speech problems? ____________________________________ ☐ 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 or patient had orthodontic treatment? _____________________________ ☐ Yes ☐ No

Signature ____ Date _________________

Doctor's Signature ______________________________________ Date __________________

Update to Medical History

Date Comments Dr Signature Patient/Guardian Signature