Submit Your Health History Form Online to Your Orthodontist

Save time at the doctor's office and fill out your registration and health history information online! Take a few minutes to fill out this confidential form, click the "Submit Form" button at the bottom, and your information will be sent to our office with secure encryption. We will already have your information when you arrive for your first appointment. You may need to provide a signature at the office to verify that the information you submitted online is accurate.

Patient Information

*Items marked with asterisk (\*) must be completed.*

First Name\*



Middle Name



Last Name\*



I prefer to be called (Nickname)



**Address**

**\***

Street



City



State/Province



Zip/Postal Code



Country



Home Phone\*



Work Phone



Cell/Other Phone



Email Address



Birth date (MM-DD-YYYY)\*



Gender\*

MaleFemale

Social Security Number (U.S. only)



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



Whom may we thank for referring you to our office?



Other family members seen by us



Responsible Party Information

Full Name\*



**Residence**

**\***

Street



City



State/Province



Zip/Postal Code



Country



**Mailing Address (if different)**

Street



City



State/Province



Zip/Postal Code



Country



Home Phone\*



Work Phone



Cell/Other Phone



Email Address



*If patient is under 18, please complete this section.*

Social Security Number (U.S. only)



Birth date\*



Relationship to Patient\*



Spouse's Name



Relationship to Patient\*



Social Security Number (U.S. only)



Birth date



Home Phone



Work Phone



Cell/Other Phone



Email Address



Dental Insurance Information

Insured's Name\*



Insured's Social Security Number (U.S. only)



Insurance Company\*



Member ID/Enrollee ID\*



Phone Number



Do you have dual coverage?



Insured's Name



Insured's Social Security Number (U.S. only)



Insurance Company



Member ID/Enrollee ID



Emergency Information

Name of the nearest relative not living with you



**Complete Address**

Street



City



State/Province



Zip/Postal Code



Country



Phone



Medical History

*Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.*

*Please check any of the following which apply to you, and add any relevant comments.*

Are you taking any medication?

Comment:



Are you allergic to any medication?

Comment:



Do you have a history of any major illness?

Comment:



Have you had any major operations?

Comment:



*Please check any of the following that you have had or currently have:*

Abnormal bleeding/Hemophilia

Anemia

Arthritis

Asthma or Hay fever

Bone Disorders

Congenital Heart Defect

Diabetes

Dizziness

Epilepsy

Gastrointestinal Disorders

Heart Problems

Heart Murmur

Hepatitis/Liver Problems

Herpes

High Blood Pressure

HIV/Aids

Kidney Problems

Pneumonia

Nervous Disorders

Prolonged Bleeding

Radiation/Chemotherapy

Rheumatic Fever

Tuberculosis

Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?



Dental History

General Dentist



Date of Last Visit



What concerns you most about your teeth?



*Please check any of the following which apply to you, and add any relevant comments.*

Are you presently in any dental pain?

YesNo

Comment:



Have you ever experienced any unfavorable reaction to dentistry?

YesNo

Comment:



Have you ever lost or chipped any teeth?

YesNo

Comment:



Have there been any injuries to face, mouth or teeth?

YesNo

Comment:



Is any part of your mouth sensitive to temperature?

YesNo

Comment:



Is any part of your mouth sensitive to pressure?

YesNo

Comment:



Do you have any type of thumb or tongue habit?

YesNo

Comment:



Have you ever seen an orthodontist?

YesNo

If yes, who?



When?



Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

YesNo

Comment:



Are you aware of your jaws clicking or popping?

YesNo

Comment:



Are you aware of clenching your teeth during the day?

YesNo

Comment:



Have you ever been told that you grind your teeth?

YesNo

Comment:



Do you have 'tension' headaches?

YesNo

Comment:



By clicking the "Submit Form" button below, you certify that the above information is correct and accurate to the best of your knowledge. All information is confidential and is accessed only via a secure, encrypted interface.

**Submit**

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