Cynthia L. Bonafield
D.D.S., M.S.

HEALTH HISTORY

Name _____ Nickname: _____ Date: _____

Date of Birth: _____ Age: _____ Physician: _____

Dentist: _____ Who may we thank for referring you: _____

Previous Orthodontic Experience: _____

Name and Ages of brothers & sisters: _____

_____

Please complete the following:	YES	NO
1. IS PATIENT NOW UNDER THE CARE OF A PHYSICIAN?	☐	☐
IF SO, FOR WHAT REASON: _____		
2. ANY OPERATIONS?	☐	☐
IF SO LIST THE OPERATION AND YEAR _____		
3. ANY SERIOUS ILLNESSES?	☐	☐
IF SO, LIST THE ILLNESS AND YEAR _____		
4. EVER HAD A NOISE IN YOUR TEMPOROMANDIBULAR JOINT?	☐	☐
(JAW JOINT/TMJ) OR TREATMENT _____		
EVER WORN SPLINTS? IF SO, PLEASE LIST _____		
5. PRESENTLY TAKING ANY MEDICATIONS?	☐	☐
IF SO, PLEASE LIST _____		
6. ALLERGIC TO ANY MEDICINE OR DRUGS?	☐	☐
IF SO, PLEASE LIST _____		
7. (FEMALES) NOW PREGNANT? WHAT MONTH? _____	☐	☐
8 WEAR CONTACT LENSES?	☐	☐
9. ARE YOU ALLERGIC TO LATEX?	☐	☐

EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)

HEART DISEASE	TUMORS	AIDS (Acquired Immune Deficiency Syndrome)
HEART ATTACK	LIVER DISEASE	FAINTING SPELLS
CHEST PAIN (ANGINA)	HEPATITIS	CONVULSIONS
HEART MURMUR	JAUNDICE	SEIZURES
CONGENITAL HEART DEFECT	STOMACH ULCER	ALLERGIES
RHEUMATIC FEVER	KIDNEY DISEASE	DIABETES
RHEUMATIC HEART DISEASE	THYROID DISEASE	SINUSITIS
HIGH BLOOD PRESSURE	TUBERCULOSIS	ARTHRITIS
STROKE	SHORTNESS OF BREATH	ANEMIA
BLEEDING DISORDER	PSYCHIATRIC TREATMENT	ASTHMA
CYSTS	GLAUCOMA	VENEREAL DISEASE

ARE YOU PRESENTLY TAKING OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING DRUGS? (PLEASE CIRCLE)

STEROIDS (CORTISONE, PREDNISONE, ETC.)
ANTICOAGULANTS (BLOOD THINNERS)
ASPIRIN

OTHER DRUGS: _____

_____

_____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE CONFIDENTIAL INFORMATION IS TRUE. IF THE ABOVE NAMED PATIENT IS A MINOR, I ALSO GIVE MY PERMISSION FOR TREATMENT.

SIGNED: _____

PATIENT INFORMATION

Name: _____ Miss _____ Mrs. _____ Mr. _____

Address: _____
(Street Address or Mailing Address) (City) (State) (Zip)

Previous Address (if less than 3 years) _____

Home Phone: _____ Work Phone: _____ No. of years at this address: _____

Male: _____ Female: _____ Marital Status: _____ Social Security: _____

Employer: _____ Occupation: _____ No. of years employed: _____

Spouse or Parent's Name: _____

Spouse or Parent's Employer: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient: _____

Address: _____
(Street Address or Mailing Address) (City) (State) (Zip)

Previous Address (if less than 3 years) _____

Home Phone: _____ Work Phone: _____ No. of years at this address: _____

Birthdate _____ Marital Status: _____ Social Security: _____

Employer: _____ Occupation: _____ No. of years employed: _____

Employer Address: _____ Phone: _____

Spouse's Name: _____ Spouse's Soc. Sec. _____

Spouse's Employer: _____ Work Phone: _____

INSURANCE INFORMATION

DENTAL:

Insured's Name: _____ Insured Social Sec. No. _____

Insurance Company: _____ Group No. _____ Local No. _____

Insurance Company Address: _____

Insured's Employer: _____

MEDICAL:

Insured's Name: _____ Insured Social Sec. No. _____

Insurance Company: _____ Group No. _____ Local No. _____

Insurance Company Address: _____

Insured's Employer: _____