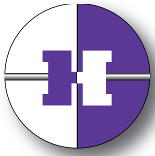


Frank R. Helm, dmd, msd
Orthodontics for Children and Adults

New Patient Information *(please write as clearly as possible)*

Date: ____________________

Patient

Legal Name: ______________________________ Nickname: ____________________

Birth Date: ____/____/____ Age: ________ Gender at Birth: ______ Pronouns: ____________

Phone: Cell ________________ ☐ Ok to text Home: ______________ Email: ________________

Address: ____

School: ______________________________________ Grade: ______

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

General Dentist: ______________________________ City: ________________

Current/Previous relative(s) in treatment at our office, Name(s): ____________________

Chief Concern: ____

Responsible Party

Guardian #1*/or Self* Name: ______________________________ Email ________________

Address: ____

Phone: Cell ________________ ☐ Ok to text Home: ______________ Work ________________

Employer: ______________________________ Occupation: ________________

Guardian #2*/or Partner* Name: ____

Address: ____

Phone: Cell ________________ ☐ Ok to text Home: ______________ Work ________________

Employer: ______________________________ Occupation: ________________

Person financially responsible for this account: ______________________ Phone: ______________

Dental Insurance

Primary

Policy Holder Name: ______________________ Birth Date ____/____/____ SSN _____ - ____ - ______

Insurance Name: ________________ Group No: ________________ Employer: ________________

Insurance Address: ______________________________ Phone: ________________

Do you have dual coverage? ☐ Yes ☐ No

Secondary

Policy Holder Name: ______________________ Birth Date ____/____/____ SSN _____ - ____ - ______

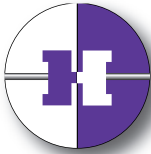
Insurance Name: ________________ Group No: ________________ Employer: ________________

Insurance Address: ______________________________ Phone: ________________

Emergency Contact

Name of nearest relative not living with you: ______________________________

Complete Address: ______________________________ Phone: ________________



Frank R. Helm, dmd, msd
Orthodontics for Children and Adults

New Patient Health History *(please write as clearly as possible)*

Patient Name:_______________________________________ Date: ____________________

Medical

Is patient in good health? ☐ Yes ☐ ***No***, ____

Name and address of physician: ____

Any serious illness or operation? ☐ No
☐ ***Yes***, explain: ____

Hospitalization or serious illness within the past five years? ☐ No
☐ ***Yes***, check all that apply:

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

Allergic to any of the following?

Aspirin / Ibuprofen	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	Latex, Metal, Plastic	☐ Yes ☐ No
Sulfa Drugs/Sulfities/Sulfides	☐ Yes ☐ No	Codeine	☐ Yes ☐ No	Local Anesthetics	☐ Yes ☐ No

Other: ____
____

List all medications currently being taken: ____
____

Dental

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

Update to Medical/Dental History:____
____

Patient or Guardian Signature: ______________________________ Date ____________

Doctor's Signature: ______________________________ Date ____________

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