Align Orthodontics
(781) 860-7997
lexington.orthodontics@gmail.com

Dr. Yong Ding D.M.D. Ph.D.
57 Bedford St, Ste 120, Lexington MA 02420
www.OrthodonticsLexington.com

Health History Form

Patient Information

* First Name: * Last Name:
* Birthdate: * Gender: Nickname:
* Address:
* City: * State: * Zip:
* Cell Phone:
* Email:

Does patient have insurance that covers orthodontics? Yes ◯ No ◯

If Yes, please name the Insurance Company:

Dental History

* Dentist Name:
Last Dental Visit: Check-up Frequency:

* Has the patient had an orthodontic consult or treatment?

Yes ◯ No ◯ If Yes, when?

What is the patient's main orthodontic concern?

* Does patient brush teeth daily? Yes ◯ No ◯
* Does patient floss teeth daily? Yes ◯ No ◯

Please select YES if the patient has had any of the conditions listed below either now or in the past.

* Speech problems/therapy? Yes ◯ No ◯
* Grind or clench teeth? Yes ◯ No ◯
* Injury to face, jaw, teeth or mouth? Yes ◯ No ◯
* Discomfort from teeth or gums? Yes ◯ No ◯
* Bleeding from gums? Yes ◯ No ◯
* Pain, tenderness or noise in either jaw? Yes ◯ No ◯
* Frequent headaches? Yes ◯ No ◯
* Oral habits (thumb/finger sucking, lip/nail biting)? Yes ◯ No ◯
* Headaches/oral facial pain? Yes ◯ No ◯
* Frequent sore throats? Yes ◯ No ◯
* Mouth breathing? Yes ◯ No ◯
* Snores during sleep? Yes ◯ No ◯
* Requires premedication? Yes ◯ No ◯
* Any missing or extra permanent teeth? Yes ◯ No ◯
* Apprehensive about dental care? Yes ◯ No ◯

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If any of the dental questions were answered 'Yes', please explain:

Medical History

Physician Name:

List any medications currently being taken by the patient:

List any drug allergies or sensitivities that the patient may have:

* Height: * Weight:

Please select YES if the patient has had any of the conditions listed below either now or in the past.

* Growth Problems?	Yes ◯	No ◯	* Diabetes?	Yes ◯	No ◯
* Latex/Metal Allergy?	Yes ◯	No ◯	* Cancer?	Yes ◯	No ◯
* Treated for Emotional Problems?	Yes ◯	No ◯	* Asthma?	Yes ◯	No ◯
* Tonsils/Adenoids Removed?	Yes ◯	No ◯	* Arthritis?	Yes ◯	No ◯
* Seizures/Epilepsy?	Yes ◯	No ◯	* HIV/AIDS?	Yes ◯	No ◯
* Received Radiation Treatment?	Yes ◯	No ◯	* Hepatitis?	Yes ◯	No ◯
* Bone Disorders/Bone Loss?	Yes ◯	No ◯			
* Take Bisphosphonates?	Yes ◯	No ◯			

If any of the above medical questions were answered 'Yes' , please explain:

If patient has any other medical conditions, please fill in here:

STOP-BANG Sleep apnea Questionnaire

* Do you SNORE loudly (louder than talking)?	Yes ◯	No ◯
* Do you feel TIRED, fatigued, or sleepy during daytime?	Yes ◯	No ◯
* Has anyone OBSERVED you stop breathing during sleep?	Yes ◯	No ◯
* Have been or being treated for high blood PRESSURE?	Yes ◯	No ◯
* BMI more than 35 kg/m2?	Yes ◯	No ◯
* AGE over 50 years old?	Yes ◯	No ◯
* NECK circumference > 16 inches (40cm)?	Yes ◯	No ◯
* GENDER Male?	Yes ◯	No ◯

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Patient Under 18

* Guardian Name: * Relationship to Patient:
* Guardian Email:
* Guardian Address:
* Guardian Phone:
* Has patient begun puberty? Yes ◯ No ◯
* Has the patient grown in the past year or has shoe size changed? Yes ◯ No ◯
* If patient is a girl, has menstruation begun? Yes ◯ No ◯ N/A ◯
* If patient is a boy, has voice changed or has facial hair grown? Yes ◯ No ◯ N/A ◯
* Has either biological parent ever had orthodontic treatment? Yes ◯ No ◯ N/A ◯
* Patient's interest in treatment? Strongly wants ◯ Wants ◯ OK with ◯ Unwilling to ◯

(Sign Here) Print Name Date