PATIENT HEALTH HISTORY FORM

PATIENT INFORMATION

Today's Date:

Patient Name:
First Last M.I.

I prefer to be called (Nickname):

Whom may we thank for referring you to our office?

Patient's Address:

City State Zip

Email Address:

Preferred Mail Method: *Circle* **Email** **Standard Mail**

Home #: **Work #:**

Cell #: **Other #:**

Patient DOB: _____ **___ Male** **___ Female**

If patient is a minor, what school does he/she attend? **Grade:**

Sports/Hobbies/Activities:

Other family members seen by us:

PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR

Who is *financially* responsible for the account:

Relationship to patient:

Parent's marital status: *Circle* **Single** **Married** **Partnered** **Widowed** **Divorced** **Separated**

Parent/Guardian #1

Name: **Birthdate:**

Address: (If different from patient)

City: **State:** **Zip:**

Relationship to Patient:

Home #: **Work #:**

Cell # **Other #:**

Email Address:

Parent/Guardian #2

Name: **Birthdate:**

Address: (If different from patient)

City: **State:** **Zip:**

Relationship to Patient:

Home #: **Work #:**

Cell # **Other #:**

Email Address:

DENTAL HISTORY

General Dentist:

Dentist Address:

City State Zip

Dentist #: **Date of Last Visit:**

What are you main concerns that you would like orthodontics to accomplish?

Have you ever been evaluated or had orthodontic treatment before?	Y	N
Do you have any metal rods, pins?	Y	N
Have there been any injuries to the face, mouth, teeth, or chin?	Y	N
Do you have any missing or extra permanent teeth?	Y	N
Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)	Y	N
Do you clench or grind your teeth?	Y	N
Do you smoke or use tobacco in any other form?	Y	N
Do you still have wisdom teeth?	Y	N
Do you have any type of thumb or tongue habit?	Y	N
Do you breathe through your mouth?	Y	N
Are you aware of your jaws clicking or popping?	Y	N

MEDICAL HISTORY

Physician:

Physician Address:

City State Zip

Physician #:

Date of Last Visit:

Are you taking any prescriptions/over the counter medication? Please list each one: ___ YES ____ NO

_____

_____

_____

Does the patient need antibiotics prior to any dental procedures? Y N

Do you have a history of any major illness? Y N

Have you had any major operations? Y N

Have you ever been involved in a serious accident? Y N

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

Abnormal Bleeding/Hemophilia	Y	N	ADD/ADHD	Y	N
Alcohol/Drug Abuse	Y	N	Anemia	Y	N
Any hospitalizations	Y	N	Arthritis	Y	N
Asthma or Hay Fever	Y	N	Blood transfusions	Y	N
Bone disorders/Artificial bones or joints	Y	N	Colitis	Y	N
Congenital heart defect	Y	N	Convulsions	Y	N
Diabetes	Y	N	Difficulty breathing	Y	N
Dizziness	Y	N	Emphysema	Y	N
Epilepsy	Y	N	Fainting	Y	N
Frequent headaches	Y	N	Gastrointestinal disorders	Y	N
Glaucoma	Y	N	Handicapped/Disabilities	Y	N
Hay fever			Hearing Impairment		
Heart Attack/Surgery	Y	N	Heart Murmur	Y	N
Hepatitis	Y	N	Hepatitis/Liver Problems	Y	N
Herpes/Fever blisters	Y	N	High Blood Pressure	Y	N
HIV/AIDS	Y	N	Kidney Problems	Y	N
Liver disease	Y	N	Low Blood Pressure	Y	N
Lupus	Y	N	Mitral valve prolapse	Y	N
Nervous Disorders	Y	N	Pacemaker	Y	N
Pneumonia	Y	N	Prosthetics	Y	N
Prolonged bleeding	Y	N	Psychiatric problems	Y	N
Radiation/Chemotherapy	Y	N	Rheumatic fever	Y	N
Scarlet fever	Y	N	Seizures	Y	N
Shingles	Y	N	Sickle cell	Y	N
Sinus problems	Y	N	STDs	Y	N
Tuberculosis	Y	N	Tumor or Cancer	Y	N
Ulcers	Y	N			

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

Are you allergic to any of the following: *Circle for YES*

Aspirin	Erythromycin	Penicillin
Codeine	Anesthetics	Latex
Metals	Tetracycline	Other:

MEDICAL HISTORY CONT.

Were Tonsils and adenoids removed?
If so, at what age? ___ YES ____ NO ___ AGE

Has patient reached puberty Y N

Is patient now experiencing a rapid growth "spurt"? Y N

FOR WOMEN:

Are you using a method of birth control? Y N

Are you pregnant? Y N Week # _____

Are you nursing? Y N

EMERGENCY INFORMATION

Name of emergency contact:

Relationship to patient:

Address:

City State Zip

Phone #:

INSURANCE INFORMATION

Primary Dental Insurance Company Name

Subscriber's Name:

Subscriber Birthdate:

Patient's Relationship to Subscriber:
___Self
___Spouse
___Parent/Guardian
___Other:

Subscriber's Address (if different from patient):

City State Zip

Insurance Company Address:

City State Zip

Insurance Phone #: **Group #:**

Member ID # (or SSN if not applicable)**:**

Subscriber's Employer:

Employer Address:

City State Zip

DO YOU HAVE A SECONDARY POLICY? ___ YES ___ NO

AUTHORIZATION

I understand that I am responsible for payment of services at the time they are rendered. Insurance claims will be submitted and payment from the insurance company will be sent to the insured. I hereby authorize Kerzner Orthodontics to release all information necessary to secure the payment of benefits. I further authorize the use of this signature on all my insurance submissions and credit card payments, whether manual or electronic.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental/orthodontic services I may need.

Signature of Patient/Parent/Guardian Date