

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? YES NO
Please list each one: _____

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 yes or no for 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 _____