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Practice Limited to Orthodontics

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MEDICAL HISTORY

Patient's Name: _____
First Middle Last

Dental Insurance: _____ Date of Birth: ____/____/____ Phone: ( )_____

Patient's Dentist: _____ Treating Office: _____

	Yes	No
Are you in good health?	____	____
Have you ever had a serious accident to head or face?	____	____
Are you under the care of a physician for any condition?	____	____
Have you ever been told that you have any of the following:		
Respiratory (breathing problems)	____	____
Diabetes	____	____
Rheumatic fever, heart murmur	____	____
Any disease of blood, liver, kidney	____	____
Any infectious disease	____	____
Hepatitis, AIDs, tuberculosis	____	____
Excessive bleeding problems	____	____
Do you have frequent colds?	____	____
Have tonsils or adenoids been removed?	____	____
Do you have any allergies? (If Yes, List Below)	____	____

_____

Are you taking any medications? (If Yes, List Below) ____ ____

_____

Please list any information you feel necessary: _____

Thank you for taking the time to complete this health history and be assured that all questions are essential to properly treat you.

- I hereby authorize release of any information to other health care providers and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature.
- I am giving my consent to your use and disclosure of my protected health information to carry out treatment and health care operations.
- I certify that the above information is complete and true to the best of my knowledge.

Date | Responsible Party | Relationship to Patient