Medical History

Have you ever had any of the following? Please check those that apply:

___AIDS	___Excessive bleeding	___Mental Disorder	___Tuberculosis
___Allergies	___Glaucoma	___Nervous Disorder	___Tumors
___Anemia	___Head Injuries	___Pacemaker	___Ulcers
___Asthma	___Heart Disease	___Current Pregnancy	___Venereal Disease
___Artificial Joints	___Heart Murmur	___Due Date:	___Codeine Allergy
___Blood Thinner	___Hepatitis	___Radiation TX	___Penicillin Allergy
___Blood Disease	___High Blood Pressure	___Respiratory TX	___Other
___Cancer	___Jaundice	___Sinus Problems	___Liver Disease
___Diabetes	___Kidney Disease	___Stomach Problems	___ **LATEX ALLERGY**
___Dizziness		___Stroke	__ **None of these**
___Epilepsy			

Please answer Yes or No and if Yes, Please Explain:

Yes No Has patient ever had any complications following a dental treatment?
Yes No Does patient have a grinding, tongue or thumbsucking habit? _____
Yes No Has patient been admitted to a hospital or needed emergency care in the last two years?
Yes No Does patient wake up with the feeling of sore teeth?
Yes No Is patient a mouth breather at night while sleeping?
Yes No When patient experience bleeding gums when brushing?
Yes No Is patient currently under the care of a physician? Name_____
Yes No Has patient ever been treated with orthodontics previously?
Yes No Has anyone in your family been treated with orthodontics?_____
Yes No Is patient currently on any medications? If yes, please list _____
_____

Do you have any health problems that need further clarifications?_____
_____

If the patient is under the age of 16, what is the height of the parent?_____Mother_____Father

Permission to email records to you and to patient's Dentist _____(Initial)

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at my next appointment.
Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment, activates, and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician, or other healthcare provider providing treatment to you. We may use your photos for demonstration purposes. **Patient Rights:** You have a right to look at or get copies of your health information with limited exceptions. I grant my permission to you and your assignee, to email or telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Signature of Patient, Parent, or Guardian Date: Relationship to Patient: