

# kravitz|orthodontics

## HEALTH HISTORY AND REGISTRATION

### PATIENT INFORMATION

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name/Initial: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female   
 S.S.N.: \_\_\_\_\_ If Patient is a Minor, Parent's/Guardians name: \_\_\_\_\_ Who may we thank for referring you to our office: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Name Of Patient's Dentist: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Name Of Patient's Physician(s): \_\_\_\_\_ Date Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Responsible Party Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name/Initial: \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Responsible Party Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_  
 S.S.N.: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### DENTAL INSURANCE INFORMATION (Primary Carrier)

Primary Policy Holder's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Dental Insurance Company (Primary Carrier): \_\_\_\_\_ Group No: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_  
 Insurance Company Address: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

### MEDICAL HISTORY

#### Now or in the past, have you had:

- yes no Birth defects or hereditary problems?  
yes no Bone fractures, any major accidents?  
yes no Rheumatoid or arthritic conditions?  
yes no Endocrine or thyroid problems?  
yes no Kidney problems?  
yes no Diabetes?  
yes no Cancer, tumor, radiation treatment or chemotherapy?  
yes no Stomach ulcer or hyperacidity?  
yes no Polio, mononucleosis, tuberculosis, pneumonia?  
yes no Problems of the immune system?  
yes no AIDS or HIV positive?  
yes no Hepatitis, jaundice or liver problem?  
yes no Fainting spells, seizures, epilepsy or neurological problem?  
yes no Mental health disturbance or depression?  
yes no Vision, hearing, tasting or speech difficulties?  
yes no Loss of weight recently, poor appetite?  
yes no History of eating disorder (anorexia, bulimia)?  
yes no Excessive bleeding or bruising tendency, anemia or bleeding disorder?  
yes no High or low blood pressure?  
yes no Tired easily?  
yes no Chest pain, shortness of breath or swelling ankles?  
yes no Cardiovascular or heart problem \_\_\_\_\_  
yes no Skin disorder?  
yes no Do you have a well-balanced diet?  
yes no Frequent headaches, colds or sore throats?

yes no Eye, ear, nose or throat condition?

yes no Hayfever, asthma, sinus trouble or hives?

yes no Tonsil or adenoid conditions?

yes no Osteoporosis?

#### Allergies or reactions to any of the following:

yes no Local anesthetics (Novocaine or Lidocaine)

yes no Aspirin

yes no Ibuprofen (Motrin, Advil)

yes no Penicillin or other antibiotics

yes no Sulfa drugs

yes no Metals (jewelry, clothing snaps)

yes no Latex (gloves, balloons)

yes no Acrylic

yes no Other substances (specify) \_\_\_\_\_

yes no Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

yes no Do you currently have or ever had a substance abuse problem?

yes no Do you chew or smoke tobacco?

yes no Hospitalized? For: \_\_\_\_\_

yes no Other physical problems or symptoms? Describe: \_\_\_\_\_

yes no Being treated by another health care professional? \_\_\_\_\_

#### Women only

yes no Are you pregnant?

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Patient Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_