Health History and Personal Information
Anita Karasko, D.M.D., Specialist in Orthodontics

Patient: _____
Date of Birth: _____/_____/_____ Age: _____
Address: _____
Town, Zip code: _____
E-Mail: _____
Phone: cel _____home:_____work:_____
Occupation_____

Dental Insurance Company _____ Gpr #_____
Subscriber_____ Subscriber ID_____
Subscriber's Employer_____
Whom may we thank for referring you to our office?_____

Please explain briefly the nature of your orthodontic concerns:
_____

Name of Dentist_____Town_____Last Visit Date _____
Name of Physician_____Town_____Last Visit Date _____

Any injuries/accidents (head, jaw, neck, facial, dental)_____
Allergies (penicillin, ibuprofen, dental anesthetic, latex, etc)_____
Taking any medications now?(pills, injections, etc)List:_____
_____

Please mark with an "X" any of the following which pertain to your history:

___ Anemia
___Anxiety
___ Arthritis
___Asthma
___AIDS/HIV
___High Blood Pressure
___Low Blood Pressure
___Bleeding disorder
___Cancer
___Clenching Habit
___Cold Sores
___Dental Trauma
___Diabetes
___Difficulty Chewing
___Earaches
___Epilepsy/Seizures
___Extractions
___Facial Trauma
___Glaucoma
___Grinding Habit
___Hay Fever
___Headaches
___Heart Disease
___Heart Murmur
___Hemophilia
___Hepatitis
___Hives
___Jaundice
___Jaw Clicking
___Jaw Pain
___Jaw Locking
___Joint Replacement
___Kidney Disorder
___Liver Disease
___Low Calcium
___Metabolism Disorder
___Mitral Valve Prolapse
___Mouth Breathing
___Oral Surgery
___Osteoporosis
___Osteopenia
___Periodontal Treatment
___Physical Therapy
___Psychological Dx
___Sinus Problems
___Smoking
___TMJ problems/TMD
___Tuberculosis
___Thyroid issues
___Rheumatic Fever
___Ulcers
___Previous Orthodontics
___Mouth breather
___Sleep Apnea

If yes to any above, please explain:

_____

Hospital stays/operations:

_____

Psychological diagnosis:

_____

Do you have any of the following habits? Please mark with and X.

___Finger/ Thumb sucking
___Clenching
___Grinding
___Smoking
___Lip sucking/biting
___Cheek biting
___Nail biting
___Mouth breathing
___Tongue thrust

Any previous orthodontic treatment? If yes, please describe:

_____

Any other information you would like to bring to our attention (ie. Pregnant?):

_____

I agree to update this record as soon as any changes occur (medical, address, insurance, etc.)

Patient Signature:_____Date:_____

Periodically, you will be asked to review the above to insure the information is current and accurate.

I have reviewed all the information above and attest it is current and accurate.

Patient Signature:_____Date_____

Patient Signature:_____Date_____

Patient Signature:_____Date_____

Patient Signature:_____Date_____

Patient Signature:_____Date_____

Patient Signature:_____Date_____