HEALTH HISTORY AND FAMILY INFORMATION
ANITA KARASKO, D.M.D.

Patient _____ Nickname_____

Date of Birth: ____/____/____ male/female _____
Patient Primary Address: _____
Town and Zip Code: _____
Phone_____Family e-mail:_____
Mother: _____ Home Tel:_____
Address:_____Cellphone:_____
Dental Insurance Co.:_____ Grp #:_____
Subscriber ID number: _____Insured D.O.B. ____/____/_____
Occupation:_____ Employer:_____

Father: _____Home Tel: _____
Address: _____ Cellphone: _____
Dental Insurance Co.:_____Grp #:_____
Subscriber ID number: _____Insured D.O.B. ____/____/_____
Occupation:_____ Employer: _____

Marital Status of parents: (Married, Single, Divorced, Separated) _____
Who does the child primarily reside with? _____
Who is responsible for this account?_____
Interests and hobbies of patient_____
Whom may we thank for referring you to our office?_____

Dentist_____Town_____Last visit date_____
Physician_____Town_____Last visit date_____

Significant accidents (head, neck, facial, dental):_____
Allergies (penicillin, ibuprofen, dental anesthetic, latex, nickel, etc)_____
Is patient taking any medication now, please list:_____

Has patient ever experienced any of the following? Please mark with an X.

Anemia	_____	Sinus problems	_____	Headaches	_____
Bleeding disorder	_____	Jaundice	_____	Earaches	_____
Hemophilia	_____	Hepatitis	_____	Clicking in jaw joint	_____
AIDS or HIV	_____	Liver disease	_____	Pain in jaw joint	_____
High blood pressure	_____	Cancer	_____	Locking of jaw	_____
Low blood pressure	_____	Herpes	_____	Chewing difficulty	_____
Mitral valve prolapse	_____	Ulcers	_____	Speech therapy	_____
Heart Murmur	_____	Gastric Reflux	_____	Eating disorder	_____
Heart disease	_____	Cold sores	_____	Easily Stressed	_____
Arthritis	_____	Epilepsy/Seizure	_____	Previous Orthodontics	_____
Rheumatic fever	_____	Kidney disease	_____	Extra adult teeth	_____
Glaucoma	_____	Attention problems	_____	Missing adult teeth	_____
Seeing Impairment	_____	ADD/ADHD	_____	Mouth breather	_____
Hearing Impairment	_____	Diabetes	_____	Tonsils removed	_____
Asthma	_____	Facial trauma	_____	Adenoids removed	_____
Hives	_____	Dental trauma	_____	Sleep Apnea	_____
Hay Fever	_____	Periodontal disease	_____	Tongue tied	_____

Does the patient have any of the following habits? Please mark with and X.

Finger sucking habit	_____	Grinding Habit	_____	Mouth breathing	_____
Thumb sucking habit		Smoking	_____	Nail biting	_____
Clenching habit	_____	Lip sucking/biting	_____	Tongue Thrust	_____

Has puberty begun Y/N ____ How long ago?_____

Any hospital stays/operations:_____
Any Psychological Diagnosis or Counseling:_____
Any other information you wish to bring to our attention to help us care for child? _____
_____
How does patient feel about wearing orthodontic appliances:_____

Please update this record with our office as soon as any changes occur- medical, address, insurance, etc.

Parent or Guardian 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.

Parent or Guardian Signature:_____Date_____

Parent or Guardian Signature:_____Date_____

Parent or Guardian Signature:_____Date_____

Parent or Guardian Signature:_____Date_____

Parent or Guardian Signature:_____Date_____

Parent or Guardian Signature:_____Date_____