CONFIDENTIAL PATIENT HEALTH HISTORY

Please Circle Any Of The Following Allergies, Disorders, Problems Or History

These Answers Are For PATIENT History ONLY, Not Family History.

Patient Name: Birthday:

ADD / ADHD	Aids / HIV	Allergies (Seasonal)	Anemia	Antibiotics
Anxiety	Arthritis	Asperger's	Asthma	Autism
Autoimmune Problems	Birth Defect	Bulimia	Bone Disorders	Cancer
Cerebral Palsy	Chest Pains	Clicking of Jaw	Cold Sores/Herpes	Diabetes
Developmental Disorder	Endocrine Problems	Emotional Disorders	Epilepsy	Fainting, Dizziness
Gag Reflex	Glaucoma	Headaches	Heart Condition	Hepatitis A B C
Immune Problems	Kidney Problems	Latex Allergy	High/Low Blood Press	Muscular Disorders
Mouth Breathing/Snoring	Nickel Allergy	Nervous Disorders	Nut Allergy	Organ Transplant
Painful Chewing	Penicillin	Periodontal Problems	Pregnant (Currently)	Prolonged Bleeding
Rheumatic Fever	Scoliosis	Seizures	Sickle Cell Anemia	Speech Problems
Thumb/Finger Habit	Thyroid Problems	TMJ Problems	Tooth Grinding	Tuberculosis

Disease, Problems Or Allergies Not Mentioned Above? Yes / No What? _____

Face, Mouth Or Teeth Injuries? Yes / No What? _____

Have You Ever Been Instructed To Take Antibiotics Or PRE-MEDICATION BEFORE Your DENTAL APPT? Yes / No What? _____

Have You Ever Had Previous Orthodontic Treatment? Yes / No When? _____

Dental Work In Progress? Yes / No Specify: _____

Current Medications: _____

REASON('s) FOR APPOINTMENT / CONSULTATION?

Cease Thumb / Finger Habit	Dentist Referral	Transfer / Continue Treatment
Evaluation	Expander / Braces / Invisalign	Treatment Options
Congenitally Missing Teeth	New Retainers	2nd / 3rd Opinion

Other_____

I Have Read And Understand The Above Questions. I Will Not Hold My Orthodontist Or Any Member Of His 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 Records Or Medical/Dental Status, I Will So Inform This Practice.

HIPAA: I give the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and healthcare operations.
I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
(Health Insurance Portability & Accountability Act Enacted by Congress on August 21, 1996)

A NOTICE OF HISER ORTHODONTICS PRIVACY PRACTICES: Is Given At Your Initial New Patient Exam / Consultation.

Patient / Parent or Guardian's Signature: _____ **Date:** _____/_____/_____

Relationship To Patient? Mother / Father / Self / Guardian / Grandparent / Stepparent / Other: _____