BLUE SKY ORTHODONTICS

HEALTH INFORMATION

6. MEDICAL HISTORY

Physician's Name: _____

Last Visit: ___/___/___ Is the patient in good health: Y N

Describe any major accidents, illness, surgery, etc:

_____

_____

Please mark "Yes" or "No" to indicate if the patient has had any of the following:

Y	N	Heart Problems	Y	N	Asthma
Y	N	Rheumatic Fever	Y	N	Seizures
Y	N	AIDS/HIV	Y	N	Bleeding Problems
Y	N	Sickle Cell Anemia	Y	N	Pregnant
Y	N	Cancer			
Y	N	Kidney Problems	Y	N	Breaths Through Mouth
Y	N	Liver Problems	Y	N	Clicking/Locking/Pain in Jaw Joint
Y	N	Thyroid Problems	Y	N	Thumb/Pacifier Habit
Y	N	Arthritis	Y	N	Speech Problems
Y	N	Diabetes	Y	N	History of Trauma to Face
Y	N	Bone Disorders (Osteoporosis, etc)	Y	N	Chipped/Injured Teeth

7. MEDICATIONS & ALLERGIES

List any medications the patient is currently taking:

_____

Allergies:

Y	N	Aspirin	Y	N	Penicilin
Y	N	Latex	Y	N	Nickel/Metal
Y	N	Local Dental Anesthetic	Y	N	Other: _____

8. DENTAL HISTORY

Dentist's Name: _____

Last visit: ___/___/___

Has the patient ever been evaluated or received orthodontic treatment? Y N Date: ___/___/___

What would you like to improve about your smile?

_____

_____

_____

9. PLEASE READ CAREFULLY BEFORE SIGNING BELOW

You understand that the information that you have given is correct to the best of your knowledge; that it will be held in the strictest of confidence and it is your responsibility to inform the office of any changes to the patient's medical status.

1. You authorize the dental staff to perform any necessary dental services that the patient may need.

2. Our office will file your insurance claim for you. You understand that you are responsible for payment of services rendered and are responsible for paying any co-pyament and deductibles that your insurance does not cover.

3. **Notice of Privacy Practice:** You have the right to read the Notice of Privacy Practices which provides description of office treatment, payment activities and healthcare operations, and of the uses and disclosures we may make to your protected health information. We may use or disclose your health information to a physician or the other healthcare provider providing treatment to you. We may use your photos for demonstration purposes.

4. You understand that where appropriate, credit bureau reports may be obtained.

_____ Date: ___/___/___ Relation to Patient: _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN (IF MINOR)