REVISED 05/01/2009

KITA ORTHODONTICS
Health History Form

Please fill out the following information as it pertains to you. This information is confidential and necessary to provide you with the best possible care. If you do not understand a question, then please ask a staff member for assistance.

Patient Name: ___________________________________

Health History:

1) Are you currently under the care of a physician? ______ For what reason? ______________________
____
2) Are you currently taking any medications? _____ If yes, please list them with dosage. ____________
____
3) Are you allergic to anything? (Drugs, foods, latex, etc.)_____ List: ______________________________
4) Do you smoke or use any other tobacco products? ___________________________
5) Have you ever been seriously ill? ______ Please explain:_____________________________________
6) Have you ever taken cortisone, steroids, or similar drugs? ______ When: _______________________
7) Have you ever bled excessively from minor cuts, previous surgery or following tooth extraction? ____
8) Have you ever been diagnosed with anemia? _________________ When? ___________________
9) Does anyone in your family have a history of: Bleeding problems_______ Who? ________________
   Diabetes ______________ Who? ________________
   Heart Disease __________ Who? ________________
10) Do you have any heart conditions (e.g. heart murmur, prosthetic valves, etc.)? __________________
11) Have you ever had rheumatic fever? __________
12) Do you have any joint prostheses'?______________ Where?_____________________
13) Have you ever had tuberculosis? _____________________________________
14) Have you ever had any liver or kidney problems? _________ Explain? _________________________
15) Have you ever had thyroid problems? __________ Are you medicated for this problem? __________
16) Are you susceptible to epileptic seizures? _________ What medication do you take?_____________
17) Have you had your tonsils removed? _____When? _____ Adenoids removed?_____ When?______
18) Have you ever been tested for AIDS? _______ Results: ___________________
19) Women --- Are you pregnant? ________
20) Have you ever had any trauma to your head or face? ______ If yes, please explain. _____________
____
21) Have any teeth been damaged due to trauma? ______ Which ones? __________________________
22) Has the patient ever sucked their thumb, finger or lip? ______ until what age? ______
23) Does the patient breathe predominantly through the mouth? ___________
24) Does the patient have any speech difficulty? _________
25) Does the patient have any noticeable difficulty in chewing and swallowing food? ______________
26) Does the patient clench or grind their teeth during the day or night? _______________
27) Does the patient experience any clicking, popping, or pain upon opening or closing of their mouth? ___________

More questions are on the back

KITA ORTHODONTICS
Health History Form

28) Does the patient notice bleeding of the gums while brushing? _______________

29) Does the patient visit the dentist regularly? ____________ Date of last visit: __________________

30) Have you been informed of any missing permanent teeth? _______________________

31) Have you been informed of any extra permanent teeth? ________________________

32) Does anyone in the family have a similar dental problem? _______________________

33) Has any member of the family had any orthodontic treatment before? ______ Who? ___________

34) Does the **patient** want his or her teeth straightened? _________

35) Are you aware of any gagging type reflex? _________

36) Do you need to be premedicated with antibiotics before you see your dentist? ________________

For Growing Patients Only

37) **Male**. Has the patient started to shave? ______
Seen his voice change? _______
Has there been any other signs of pubertal development? (i.e. axillary hair, etc.) ______

38) **Female**. Has the patient started her monthly period? _____ Age? ____
Has there been any signs of pubertal development? (i.e. axillary hair, etc.) ______

What is the reason for visiting our office today?

____

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek reimbursement from the other parent. To the best of my knowledge, the above information and the information on the form named 'Kita Orthodontics Patient and Parent Information' are complete and correct. I understand that incomplete or inaccurate information could be hazardous to my health and/or the health of the doctor and his staff. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

_______________ _____________________________ _____________________________

Date Signature of Patient Signature of Parent or Guardian

_______________ _____________________________

Date reviewed Signature of doctor

For Office Use Only

Date: ________________ Health History Update:

___________________________ ___________________________________

Signature of doctor Signature of patient/parent

Date: ________________ Health History Update:

___________________________ ___________________________________

Signature of doctor Signature of patient/parent