Virginia Center for Orthodontics

Dr. Crissy Markova

Health History Form

Welcome! We are thrilled you're here!

Patient's Name_____ Patient's Date of Birth____/_____/_____

Address _____ City_____ State_____ Zip_____

Phone (Home) _____ (Cell) Phone_____ (Work) Phone_____

Preferred Email_____

Who may we thank for referring you to our practice? _____

Insurance Information

Insurance Company _____

Insurance Policyholder's Name _____ Date of Birth____/_____/_____

Insurance Policyholder's Address _____City_____ State_____ Zip_____

Patient's Relationship to Policyholder _____

Insurance Policyholder's Social Security Number _____

- **SSN required to check orthodontic insurance benefits**
- **Please give ALL responsible party's insurance cards to the front desk**

Financial Party Information

Responsible Party Name _____ Date of Birth____/_____/_____

Relationship to Patient _____

Phone (Home) _____ (Cell) Phone_____ (Work) Phone_____

2nd Responsible Party Name (if applicable) _____ Date of Birth____/_____/_____

Relationship to Patient _____

Phone (Home) _____ (Cell) Phone_____ (Work) Phone_____

Dental History

Name of General Dentist_____ Location _____

Month of last dental checkup_____

Is there any dental work (filling, root canal, crown, extraction, etc.) that you have planned or that needs to be done?

_____

Missing teeth? _____

Prior orthodontic treatment?	YES	NO
Apprehensive about dental care?	YES	NO
Prior deep cleanings needed?	YES	NO
Prior gum grafts?	YES	NO
Speech problems/therapy?	YES	NO
Thumb/finger sucking (past or current)?	YES	NO
Trauma or accident to face or teeth?	YES	NO

Continue →

Sleep Apnea History

Mouth breathing?	YES	NO
Snores during sleep?	YES	NO
Sleepy during the day?	YES	NO
Wake up gasping for air?	YES	NO

TMJ History (Jaw Joint)

Do you have TMJ problems?	YES	NO
Grinding or clenching teeth?	YES	NO
Ever worn a night guard?	YES	NO
Frequent headaches in the morning?	YES	NO
Sore jaw or neck muscles?	YES	NO
Bite shifted or changed recently?	YES	NO

Medical History

Requires pre-medication with antibiotics? YES NO

List medical conditions:

List medications currently taken:

Any history of:

Radiation Therapy?	YES	NO
Bisphosphonate Therapy?	YES	NO
Hormone Therapy?	YES	NO
Autism?	YES	NO
Sensory Problems?	YES	NO
Growth Problems?	YES	NO
Heart valve replacement?	YES	NO
Diabetes?	YES	NO
Endocrine Problems?	YES	NO
Rheumatoid joint conditions?	YES	NO

Patients Under 18

School_____

Sports_____

If patient is a girl, has menstruation begun? YES NO

If patient is a boy, has voice changed? YES NO

HIPAA PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility.

Please Initial and Sign:

_____ In accordance with HIPAA regulations (refer to laminated forms), I understand that this information will be held in strict confidence. I hereby give my permission for the office of the Virginia Center for Orthodontics to use patient records for diagnosis, treatment, promotion, and education.

_____ I authorize VCO Orthodontics to release any information necessary for insurance purposes and authorize direct payment of insurance benefits to Dr. Markova for services rendered.

_____ I understand the risks of unencrypted email and give my consent for VCO Orthodontics to use unencrypted email to communicate with me and my dentist regarding personal health information (appointment scheduling, billing & payment, orthodontic care & treatment, X-rays, and emergency questions).

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient or Responsible Party _____ Date_____