

**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

Dr. Crissy Markova

Continue

**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

**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:

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_