HEALTH HISTORY

PEAK ORTHODONTICS

Patient First Name: _____

Patient Last Name: _____

Indicate which of the following you HAVE HAD or have at present (**circle "yes" or "no"** to each item)

Have you been under the care of a medical doctor during the past two years? ..... **YES** **NO**
Physician's Name: _____ Phone #: _____
Address_____ State_____
Have you been a patient in the hospital during the past two years? ..... **YES** **NO**
If yes, please explain: _____
Please list any medication or drugs taken during the past two years: _____
Are you taking any medication or drugs at this time? ..... **YES** **NO**
If yes, please list: _____
Are you sensitive or allergic to any medication or anesthetics? ..... **YES** **NO**
When you walk upstairs, or take a walk, do you ever have to stop because of pain in your chest? ..... **YES** **NO**
Do your ankles swell during the day? ..... **YES** **NO**
Do you ever wake up from sleep and feel short of breath? ..... **YES** **NO**
Have you lost or gained more than 10 pounds in the past year? ..... **YES** **NO**
If yes, please list: _____ **YES** **NO**
Are you on a special diet? ..... **YES** **NO**
If yes, please list: _____
Are you having tooth pain or discomfort at this time? ..... **YES** **NO**
If yes, please list: _____
Do you have Jaw Soreness? ..... **YES** **NO**
When was your last dental cleaning?_____

ADD/ADHD.....	**YES**	**NO**	Stroke.....	**YES**	**NO**	Ulcers.....	**YES**	**NO**
Heart Murmur.....	**YES**	**NO**	Cancer.....	**YES**	**NO**	Cold Sore/Fever Blister...	**YES**	**NO**
Mitral Valve Prolapse...	**YES**	**NO**	Chemotherapy.....	**YES**	**NO**	Allergy to Latex.....	**YES**	**NO**
Rheumatic Fever.....	**YES**	**NO**	Radiation therapy.....	**YES**	**NO**	Allergy to Nickel.....	**YES**	**NO**
High Blood Pressure.....	**YES**	**NO**	Diabetes.....	**YES**	**NO**	Tumors.....	**YES**	**NO**
Heart Disease or Attack	**YES**	**NO**	Asthma.....	**YES**	**NO**	Liver Disease.....	**YES**	**NO**
Angina Pectoris.....	**YES**	**NO**	Hay Fever.....	**YES**	**NO**	Hepatitis A (infection)..	**YES**	**NO**
Artificial Joints (knee)....	**YES**	**NO**	Allergies or Hives.....	**YES**	**NO**	Hepatitis B (Serum).....	**YES**	**NO**
Artificial Heart Valve....	**YES**	**NO**	Sinus Trouble.....	**YES**	**NO**	Venereal Disease.....	**YES**	**NO**
Heart Pacemaker.....	**YES**	**NO**	Chronic Cough.....	**YES**	**NO**	A.I.D.S	**YES**	**NO**
Heart Surgery.....	**YES**	**NO**	Emphysema.....	**YES**	**NO**	H.I.V. Positive.....	**YES**	**NO**
Heart Failure.....	**YES**	**NO**	Tuberculosis.....	**YES**	**NO**	Blood Transfusion.....	**YES**	**NO**
Heart Disease.....	**YES**	**NO**	Fainting/Dizzy spells.....	**YES**	**NO**	Anemia.....	**YES**	**NO**
Arteriosclerosis.....	**YES**	**NO**	Seizures/Epilepsy.....	**YES**	**NO**	Sickle Cell Disease.....	**YES**	**NO**
Arthritis.....	**YES**	**NO**	Thyroid Problems.....	**YES**	**NO**	Bruise Easily.....	**YES**	**NO**
Rheumatism.....	**YES**	**NO**	Glaucoma.....	**YES**	**NO**	Development Disabled...	**YES**	**NO**
Cortisone Medication...	**YES**	**NO**	Kidney Trouble.....	**YES**	**NO**	Nervousness.....	**YES**	**NO**

Do you have, or have you had, any disease, condition, or problem not listed?
If yes, please list: _____

FOR WOMEN ONLY: Are you pregnant.....**YES** Due Date: _____ **NO**, are you nursing?.....**YES** **NO**
Are you taking birth control pills?.....**YES** **NO**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient/Parent Signature _____ Date: _____

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor, and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I acknowledge that I have reviewed a copy of the Notice of Privacy Practices.
5. I understand that, where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Parent Signature _____ Date: _____

REVIEWED BY: _____ Date: _____ Witness: TR
Dr. Tharon Smith