Heather K. Burch, D.M.D., M.S.

Orthodontics for Children and Adults

Welcome to our office! We care about your total health and appreciate your time in completing this health history

Patient Information

Patients Name _____Nickname_____
Last First Middle

Address_____
Street City State Zip

Primary Phone # _____ (C / H / W) Secondary Phone # _____ (C / H / W)

DOB _____ Age _____ Gender F / M School/Grade_____

If patient is a minor, parent's or natural guardian's name _____

How did you hear about us? _____

Siblings/Children Names and Ages_____

Responsible Party Information

Name_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address? _____ Own____ Rent____ Primary Phone # _____

Social Security #_____-_____-_____ DOB _____ Relationship to Patient_____

Employer_____ Work Phone_____

Spouse's Name_____ DOB _____

Spouse's Employer_____ Work Phone_____

Spouse' Social Security #_____-_____-_____

Orthodontic Insurance Information

Policy Holder Name_____ Policy Holder SS#_____-_____-_____

Employer _____

Insurance Company_____ Group #_____Member #_____

Insurance Company Address_____Phone_____

Do you have dual coverage ____yes ____no

If yes: Policy Holder Name_____SS#_____-_____-_____Employer_____

I hereby authorize payment directly to the above named orthodontist of the group insurance benefits otherwise payable to me.

_____ _____ _____ _____
Primary Insurance Company Date Signature Date

_____ _____
Secondary Insurance Company Date

I certify this information is accurate and up to date to the best of my knowledge.

_____ _____
Signature of Patient/ Natural Guardian* Date

Reviewed with patient by _____
Date_____

Medical History

Physician_____ Date of Last Visit_____
Address_____Phone_____
Please circle yes or no. If yes please detail.

yes no Are you currently taking medication?_____
yes no Are you allergic to any medications?_____
yes no Do you have a history of a major illness?_____
yes no Have you had any major operations?_____
yes no Have you been involved in a serious accident?_____
yes no Have you ever been told to pre-medicate before dental appointments?_____
yes no Are you currently pregnant or think you may be pregnant?_____
yes no Do you use tobacco products__, drink alcohol__, or use illegal drugs__ Please check the one that applies.

Circle any of the medical conditions below that you have had or currently have

Abnormal bleeding	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay-fever	GI Disorders	HIV+	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous disorder	Tumor or Cancer

*Are there any medical problems that we should be aware of that are not listed here? Is there anything you would like to discuss privately with the doctor? Yes No

_____

Dental History

Dentist_____ Date of Cleaning_____
Address_____Phone_____

yes no Are you in dental pain?_____
yes no Have you ever lost or chipped any teeth?_____
yes no Have there been injuries to your head/face?_____
yes no Do your gums bleed when you brush/floss?_____
yes no Do you have a tongue or thumb habit?_____
yes no Have you ever been treated by an orthodontist?_____
yes no Has anyone in your family been treated by an orthodontist?_____
yes no Are you aware of you jaw clicking or popping?_____
yes no Do you clench or grind your teeth?_____
yes no Do you have a history of headaches?_____

I understand that all the above information is confidential. I assert that all the information is true and I will report any changes in my medical history to Dr. Burch or her staff.

_____ _____
Signature of Patient/ Natural Guardian* Date

*Participants under 18 years old must have health history form completed by their "natural guardian" as defined by Florida Statute FS 744.3011 which defines a natural guardian as the child's mother or father by birth or adoption, or if parents are divorced the parent to whom custody is awarded. NOTE: the State of Florida **only** allows for a natural guardian to complete forms on behalf of minor participants.