Health History and Personal Information
Anita Karasko, D.M.D., Specialist in Orthodontics

Patient ______________________________________ Date of Birth ____/____/____ Age________
Address______________________________________ Telephone(home)____________________________
______________________________________ (work)____________________________
Town ______________________________________ CellPhone _________________________________
Occupation____________________________________ E-Mail _________________________________

Orthodontic Insurance Coverage Yes____No____ Insurance Company _________________________
Insured's Name ______________________________ Insured's Social Security # _____ -_____-______
Group#______________________________________ ID number: ________________________________

Whom may we thank for referring you to our office?____
Please explain briefly the nature of your orthodontic concerns ___________________________________
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Name of Dentist_________________________Town______________________Last Visit Date _________
Name of Physician_______________________Town______________________Last Visit Date _________
Previous illnesses or hospitalizations: ____
Any injuries/accidents (head, jaw, neck, facial, dental)____
Allergies (penicillin, ibuprofen, dental anesthetic, latex, etc)___________________________________
Taking any medications now?(pills, injections, etc)List:____
____

- Please check any of the following concerns which pertain to your history:

__Anemia	__Glaucoma	__Liver Disease
__Arthritis	__Grinding Habit	__Low Calcium
__Asthma	__Hay Fever	__Metabolism Disorder
__AIDS/HIV	__Headaches	__Mitral Valve Prolapse
__High Blood Pressure	__Heart Disease	__Mouth Breathing
__Low Blood Pressure	__Heart Murmur	__Oral Surgery
__Bleeding disorder	__Hemophilia	__Osteoporosis
__Cancer	__Hepatitis	__Periodontal Treatment
__Clenching Habit	__Hives	__Physical Therapy
__Cold Sores	__Jaundice	__Psychological Disorder
__Diabetes	__Jaw Clicking	__Sinus Problems
__Difficulty Chewing	__Jaw Pain	__Tuberculosis
__Earaches	__Jaw Locking	__Rheumatic Fever
__Epilepsy/Seizures	__Joint Replacement	__Ulcers
__Facial Trauma	__Kidney Disorder	__Previous Ortho TX

If yes to any above, please explain:____
____
Any other information you would like to bring to our attention?(ie. currently pregnant)_______________
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Signature ____Date________________________