HEALTH HISTORY AND FAMILY INFORMATION
ANITA KARASKO, D.M.D.

Patient______________________________ Nickname___________________ Date of Birth___/____/____
Patient Primary Address: ____ Phone___________________
Family e-mail:____

Mother: ____ Home Tel:________________________________
Address:____Cellphone:_________________________________
Occupation:_____________________________________ Employer:________________________________

Father: ____Home Tel: _________________________________
Address: ____ Cellphone:________________________________
Occupation:______________________________________ Employer:_________________________________
Marital Status of parents: Married _____ Single_____ Divorced_____ Separated_____

Orthodontic Insurance Company_________________________________Grp Number:___________________
Insured's ID number: Father_________________Mother__________________Insured D.O.B.___/____/_____
Who is responsible for this account?____________________________responsible SSN ______-_____-______

Interests and hobbies of patient____
Whom may we thank for referring you to our office?____
Dentist______________________________________Town_________________Last visit date_____________
Physician____________________________________Town_________________Last visit date_____________
Previous illnesses or hospitalizations:____
Significant accidents (head, neck, facial, dental):____
Allergies (penicillin, ibuprofen, dental anesthetic, latex, nickel, etc)__________________________
Is patient taking any medication now, please list:____

Has patient ever experienced any of the following:

Anemia	_____	Heart murmur	_____	Finger/thumb habit	_____
Arthritis	_____	Glaucoma	_____	Mouth breathing	_____
Asthma	_____	Heart disease	_____	Clicking in jaw joint	_____
AIDS or HIV	_____	Hemophilia	_____	Pain in jaw joint	_____
Attention problems	_____	Herpes	_____	Headaches	_____
Bleeding disorder	_____	Hepatitis	_____	Locking of jaw	_____
High blood pressure	_____	Hives	_____	Earaches	_____
Low blood pressure	_____	Jaundice	_____	Chewing difficulty	_____
Cancer	_____	Kidney disease	_____	Clenching habit	_____
Cold sores	_____	Liver disease	_____	Grinding Habit	_____
Diabetes	_____	Mitral valve prolapse	_____	Speech therapy	_____
Epilepsy/Seizure	_____	Rheumatic fever	_____	Periodontal disease	_____
Hay Fever	_____	Facial trauma	_____	Easily stressed	_____
Ulcers	_____	Sinus problems	_____		

Any other information you wish to bring to our attention?____
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Please update this record with our office as soon as any changes occur- medical, address, insurance, etc.

Parent or Guardian Signature:_______________________________________Date____________