ORTHODONTIC ASSOCIATES OF LITTLE NECK

Orthodontic Associates of Little Neck

Practice Limited to Orthodontics

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MEDICAL HISTORY

Patient's Name: _____
First Middle Last

Patient's Nickname: _____ Date of Birth: ____/____/____

Patient's Dentist: _____ Treating Office: _____

	Yes	No
Are you in good health?	☐	☐
Have you ever had a serious accident to head or face?	☐	☐
Are you under the care of a physician for any condition?	☐	☐
Have you ever been told that you have any of the following:		
Respiratory (breathing problems)	☐	☐
Diabetes	☐	☐
Rheumatic fever, heart murmur	☐	☐
Any disease of blood, liver, kidney	☐	☐
Any infectious disease	☐	☐
Hepatitis, AIDs, tuberculosis	☐	☐
Excessive bleeding problems	☐	☐
Do you have frequent colds?	☐	☐
Have tonsils or adenoids been removed?	☐	☐
Do you have any allergies? (If Yes, List Below)	☐	☐

_____

Are you taking any medications? (If Yes, List Below)	☐	☐

_____

Please list any information you feel necessary: _____

_____

Thank you for taking the time to complete this health history and be assured that all questions are essential to properly treat you.

- I hereby authorize release of any information to other health care providers and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature.
- I am giving my consent to your use and disclosure of my protected health information to carry out treatment and health care operations.
- I certify that the above information is complete and true to the best of my knowledge.

Date _____ Signature (Parent's if minor) _____ Relationship to Patient _____