NEW PATIENT HEALTH HISTORY
ALL INFORMATION IS CONFIDENTIAL

PATIENT INFORMATION			
First Name:	Middle Initial:	Last Name:	
Address:	State:	Zip Code:	
Main Phone:	Cell Phone:		Work Phone:

Please List Name and Birthdate of Patient's Siblings:

Name: ______________________ Birthday: _____/_____/_____	Name: ____________________Birthday: ______/_____/______
Name: ______________________ Birthday: _____/_____/_____	Name: ____________________ Birthday: _____/_____/______

FINANCIAL INFORMATION		
First Name:	Middle Initial:	Last Name:
Birthdate:	Relationship to Patient:	Email:
Dental Insurance:	Subscriber's Name:	Subscriber's Date of Birth:
Insurance ID or SSN:	Group#:	Name of Employer:
Address if Different From Patient:	City:	State:
Dental Insurance 2:	Subscriber's Name:	Subscriber's Date of Birth:
Insurance ID or SSN:	Group#:	Name of Employer:

DENTAL HISTORY

	YES	NO	IF YES PLEASE DESCRIBE
Any Allergies to drugs or material (Latex, nickel, ect)?	☐	☐	
Injury to face, jaw, teeth or mouth?	☐	☐	
Oral Habits (thumb/finger sucking, lip/nail biting)?	☐	☐	
Mouth Breathing?	☐	☐	
Has patient had been evaluated for orthodontics?	☐	☐	

CO CAMPUS
ORTHODONTICS

	YES	NO	IF YES PLEASE DESCRIBE
Is there is Anything in your smile that you would like to improve?	☐	☐	
FEMALES: Is the patient pregnant?	☐	☐	DUE DATE:

MEDICAL HISTORY

	YES	NO	IF YES PLEASE DESCRIBE
Is the patient currently under the care of a physician?	☐	☐	
Is the patient taking any prescriptions/ over the counter drugs?	☐	☐	
Does the patient smoke or use tobacco in any other form?	☐	☐	

Has the patient had any of the following conditions?	YES	NO		YES	NO
Abnormal Bleeding/ Hemophilia	☐	☐	Herpes/Fever Blister	☐	☐
AIDS or HIV positive	☐	☐	High/ Low Blood Pressure	☐	☐
Anemia	☐	☐	Kidney Problems	☐	☐
Arthritis	☐	☐	Psychiatric Problems	☐	☐
Artificial Bones/Joints/Valves	☐	☐	Speech Problems	☐	☐
Asthma	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Thyroid Problems	☐	☐
Epilepsy or Seizures	☐	☐	Tuberculosis	☐	☐
Hepatitis	☐	☐	Ulcer	☐	☐

Please list any serious medical condition that the patient ever had:

Signature on File for Release of Information, assignment of benefits, and guarantee of payment

I authorize KRiSTAL SMILES PLLC, to release medical and/or dental information or any information pertaining to examination, treatment, history and medical or dental expenses to my insurance company(ies) for the purpose of processing insurance claims. This release may include the reviewing and/or copying of pertinent documents x-rays, or other clinical information for purposes of payment by my insurance company. I authorize payment of medical or dental insurance benefits to be made directly to KRiSTAL SMILES PLLC. I permit a copy of this authorization to be used in place of original. I further agree to accept full responsibility for payment of charges rendered to the above patient which are not paid by an insurance company.

Signature:________________________ Print Name:________________________ Date: ____/____/____

If guarantor, relationship to the patient:____

Doctor's Signature:____ Date: ____/____/____