PATIENT HEALTH HISTORY

Patient Name: _____ **Patient DOB:** _____ **Today's Date:** _____

Circle if you currently have or have ever had (now or in the past):

Pain or tenderness in jaw (TMJ Asthma Seizures/Epilepsy Hemophilia Hormone Therapy

Congenital Heart Defect Hepatitis Mitral Valve Prolapse High Blood Pressure

Rheumatic Fever Adenoids/Tonsils removed Heart Murmur Bone Disorders

Females only: Pregnant? Yes or No

List any prescription or over the counter medications: _____

List any allergies (i.e., latex, penicillin, etc.): _____

At Thurman Orthodontics, we will give the patient a beautiful healthy smile, but it's up to him/her to maintain health teeth and gums. We are not a general dentist office, and braces and Invisalign treatment is all we do at Thurman Orthodontics. We do not diagnose cavities and other dental problems so we rely on the patient visiting their dentist and completing all needed dental treatment prior to starting any treatment with us. I acknowledge that the patient is in good dental health, and doesn't have any outstanding dental work that needs to be completed. I also understand that the patient needs to maintain regular dental check-ups at all times while wearing braces or Invisalign.

I have read and understand the above questions and will not hold Thurman Orthodontics responsible for any errors or omissions that I have made in the completion of this form. I authorize the dental staff to obtain insurance benefits and perform the necessary orthodontic service my child may need. I also understand Thurman Orthodontics is not responsible for any unsupervised children. I have received the Notice of Privacy Practices of Thurman Orthodontics.

_____

Printed Full Name Signature (Parent/Guardian if minor) Date

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