

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)?	<input type="checkbox"/>	<input type="checkbox"/>	
Injury to face, jaw, teeth or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Habits (thumb/finger sucking, lip/nail biting)?	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth Breathing?	<input type="checkbox"/>	<input type="checkbox"/>	
Has patient had been evaluated for orthodontics?	<input type="checkbox"/>	<input type="checkbox"/>	

KRISTAL SMILES⁺

Smile Studio

	YES	NO	IF YES PLEASE DESCRIBE
Is there is Anything in your smile that you would like to improve?	<input type="checkbox"/>	<input type="checkbox"/>	
FEMALES: Is the patient pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	DUE DATE: _____

MEDICAL HISTORY

	YES	NO	IF YES PLEASE DESCRIBE
Is the patient currently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the patient taking any prescriptions/ over the counter drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the patient smoke or use tobacco in any other form?	<input type="checkbox"/>	<input type="checkbox"/>	

Has the patient had any of the following conditions?

	YES	NO		YES	NO
Abnormal Bleeding/ Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/Fever Blister	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	High/ Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Bones/Joints/Valves	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>

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

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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: ____/____/____