CONFIDENTIAL 636 Easton Avenue, Somerset, 732-846-8686 Ortho II Code:_____

PATIENT INFORMATION

Date:__/__/____

Patient Name:_____ Nickname:_____
First Last

Date of Birth:__/__/__ Age:_____ Male/Female:_____Home phone #:(___) ___–____

Address:_____
Street/Apt.# City State Zip

Your email address: _____ Cell Phone #:(___) ___–____

What is the best number and time to reach you during the day?(___) ___–____ ____AM/PM

Dentist:_____ Referred by:_____

Dentist's Town and Phone #:_____

Employer:_____

Business Address:_____

Bus. Phone #:(___) ___–____ S.S.#:___–___–____

Husband/Wife's Name:_____

Person Responsible For This Account:_____
Other family members or friends treated here: _____

Do You Have Dental Insurance for Orthodontics?_____
If Yes, Name of Insurance Company:_____
Spouse - If Yes, Name of Insurance Company:_____
Which Insurance Company is Primary:_____

What is your primary concern — Why are you here?_____
_____

MEDICAL AND DENTAL HISTORY

For the following questions, circle **yes**, **no**, or don't know/understand (**dk/u**). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

yes	no	dk/u	Birth defects or hereditary problems?	yes	no	dk/u	Hepatitis, jaundice or liver problems?
yes	no	dk/u	Bone fractures, any major accidents	yes	no	dk/u	AIDS or HIV positive?
yes	no	dk/u	Rheumatoid or arthritic conditions?	yes	no	dk/u	Sexually transmitted disease?
yes	no	dk/u	Endocrine or thyroid problems?	yes	no	dk/u	Fainting spells, seizures, epilepsy or neurologic disease?
yes	no	dk/u	Kidney Problems?				
yes	no	dk/u	Diabetes?	yes	no	dk/u	Mental health or behavioral problems?
yes	no	dk/u	Cancer or been treated for a tumor?	yes	no	dk/u	Vision, hearing, tasting or speech difficulties?
yes	no	dk/u	Stomach ulcer or hyperacidity?	yes	no	dk/u	Loss of weight recently, poor appetite?
yes	no	dk/u	Polio, mononucleosis, tuberculosis, pneumonia?	yes	no	dk/u	Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
yes	no	dk/u	Problems of the immune system?				

(over)

CONFIDENTIAL

yes no dk/u High or low blood pressure?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Easily tired?
yes no dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
yes no dk/u Skin disorder?
yes no dk/u Do you have a normal and good diet?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Any history of speech problems?
yes no dk/u Eye, ear, nose, throat condition?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Allergies or drug reactions?
yes no dk/u Are you taking medication, nutrient supplements or non prescription medicine? Please name them:

_____
_____
_____

yes no dk/u Do you currently have or ever had a substance abuse problem?
yes no dk/u Ever been in an auto accident?
yes no dk/u Operations? For _____
_____
_____
_____
_____

yes no dk/u Hospitalized? For _____
_____
_____
_____
_____

yes no dk/u Other physical problems or symptoms?
yes no dk/u Being treated by another health care professional? For _____
_____
_____

yes no dk/u Are you in good health? Date of most recent physical exam: _____

Female Patient

yes no dk/u Are you pregnant?
yes no dk/u Are you taking birth control pills?
yes no dk/u Are you anticipating becoming pregnant?

Dental History

yes no dk/u Chipped or otherwise injured permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts, mouth infection?
yes no dk/u "Dead Teeth", root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u "Gum Boils", frequent canker sores, cold sores?
yes no dk/u Thumb, finger, sucking habit? Until _____
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Do you experience any pain or soreness in the muscles of your face, or around the ears?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain)?
yes no dk/u Difficulty encountered in chewing or jaw opening?
yes no dk/u History of supernumerary (extra) or congenitally missing teeth?
yes no dk/u Have any permanent teeth been removed?
yes no dk/u Aware of loose, broken or missing fillings?
yes no dk/u Any teeth irritating cheek, lip, tongue, palate?
yes no dk/u Have you ever had Orthodontic treatment or worn a "retainer" or "bite plate"?
yes no dk/u Have you recently been under another dentist's care? Specialist _____
yes no dk/u Have you ever had Periodontal (gum) treatment?
yes no dk/u Concern about spaced, crooked, protruding teeth?
yes no dk/u Any relative with similar tooth or jaw relationships?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Have you had any serious trouble associated with any previous dental treatment?
yes no dk/u Problems opening or closing your mouth?
yes no dk/u Clicking or popping sounds in your jaw joints?
yes no dk/u History of trauma to the jaw or face?

Date of most recent dental examination: _____
How often do you brush? _____ floss?_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instruction, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____
_____
_____

I have read and understand the above questions. I will not hold Dr. Silverstein or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____
Signature of patient Date

Medical History Update or Changes: Date: Comments: Signature

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