

PATIENT INFORMATION

Date: ____ / ____ / ____

Patient Name: _____ Nickname: _____
First Last

Date of Birth: ____ / ____ / ____ Age: _____ Male/Female: _____ Home phone #: (____) ____ - _____

Address: _____
Street/Apt.# City State Zip

Person Responsible For This Account: _____

Responsible Party's email: _____ Patient's email: _____

What is the best number and time to reach you during the day? (____) ____ - _____ AM/PM

Cell Phone #: (____) ____ - _____

Dentist: _____ Referred by: _____

Dentist's Town and Phone #: _____

Father's Name: _____ S.S.#: _____ - _____

Address (if different): _____

Phone #: (____) ____ - _____ Employed by: _____

Business Address: _____ Bus. Phone #: (____) ____ - _____

Mother's Name: _____ S.S.#: _____ - _____

Address (if different): _____

Phone #: (____) ____ - _____ Employed by: _____

Business Address: _____ Bus. Phone #: (____) ____ - _____

Other family members or friends treated here: _____

Do You Have Dental Insurance for Orthodontics?: _____

Mother - Name of Insurance Company and YOUR birthday: _____

Father - Name of Insurance Company and YOUR birthday: _____

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.

- yes no dk/u Does patient follow directions? yes no dk/u Endocrine or thyroid problems?
yes no dk/u Does patient brush his/her teeth conscientiously? yes no dk/u Kidney Problems?
yes no dk/u Does patient have learning disabilities or need extra help with instructions? yes no dk/u Diabetes?
yes no dk/u Is patient sensitive, self-conscious? yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Stomach ulcer or hyperacidity?
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 Mental health or behavioral problems?
yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia? yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Fainting spells, seizures, epilepsy or neurologic problems? yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u Problems of the immune system?

CONFIDENTIAL

yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
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 Tires easily?
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 Does patient 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 Is patient taking medication, nutrient supplements or non prescription medicine? Please name them:

yes no dk/u Does patient currently have or ever had a substance abuse problem?
yes no dk/u Operations? For

yes no dk/u Hospitalized? For

yes no dk/u Ever been in an auto accident?
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 Is patient in good health? Date of most recent physical exam: _____

Female Patient

yes no dk/u Is patient pregnant?
yes no dk/u Is patient taking birth control pills?
yes no dk/u Has patient had first menstrual cycle? If yes, month and year: _____

Dental History

yes no dk/u Started teething very late?
yes no dk/u Primary (baby) teeth removed that were not loose?
yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
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 Is patient taking any forms of fluoride?
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 Any pain or soreness in the muscles of the face, or around the ears?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Ever been treated for "TMJ" problems (Jaw joint and facial muscle pain)?
yes no dk/u Difficulty encountered in chewing or jaw opening?
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 Has patient ever had Orthodontic treatment or worn a "retainer" or "bite plate"?
yes no dk/u Has patient recently been under another dentist's care? Specialist: _____
Other: _____
yes no dk/u Has patient 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 Has patient had any serious trouble associated with any previous dental treatment?
yes no dk/u Problems opening or closing the mouth?
yes no dk/u Clicking or popping sounds in the jaw joints?
yes no dk/u History of trauma to the jaw or face?

Date of most recent dental examination: _____
How often does patient 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 parent or guardian _____ Date _____

Medical History Update or Changes: Date: _____ Comments: _____ Signature _____

