CONFIDENTIAL

32 Worlds Fair Drive, Suite 101
Somerset, NJ 08873 732-560-0022

Ortho II Code:_____
Records Date: _____

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: _____

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

Mother's or Father's (circle one) Cell Phone # :(___) ___–_____

Dentist:_____ Referred by:_____

Dentist's Town and Phone #:_____

Other family members or friends treated here: _____

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 #:(___) ___–_____

Dental Insurance

Mother: Dental Insurance Company Name: _____Birth Date: _____

ID Number from your insurance card: _____Group #:_____

Father: Dental Insurance Company Name: _____Birth Date: _____

ID Number from your insurance card: _____Group #:_____

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	Cancer or been treated for a tumor?
yes	no	dk/u	Is patient sensitive, self-conscious?	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 age:

_____

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?
yes no dk/u Has the patient, or anyone in the immediate family been told by a dentist that any teeth (or the family member’s teeth) have short roots?

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

_____
_____
_____
_____
_____
_____
_____
_____