Family Orthodontics

Adelina M. Das, DMD, MSD

PATIENT INFORMATION: **Date**: _____

First Name MI Last Name Preferred Name

Street Address City/State Zip Code Phone Number

M F

Date of Birth Gender School Grade Email

PATIENTS DENTIST: _____ City/State: _____

Last Seen: _____ Next Visit: _____

PATIENTS PHYSICIAN: _____ City/State: _____

Last seen: _____ Next Visit: _____

GENERAL INFORMATION:

Concerns about the patient's teeth: _____

How often does the patient brush: _____ Floss: _____

Has had previous orthodontic treatment or consultation: YES NO

How did you hear about us: _____

If patient is a minor please fill out below:

Father/Guardian full name: _____

Occupation: _____ Email: _____

Phone Number: (cell) _____ (work) _____

Mother/Guardian full name: _____

Occupation: _____ Email: _____

Phone Number: (cell) _____ (work) _____

Patient Siblings name(s): _____

DENTAL INSURANCE: Primary policy holder full name: _____

Birth Date: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

Employer: _____ Insurance Company: _____

Group Number: _____ Identification Number: _____

Secondary policy holder full name: _____

Birth Date: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

Employer: _____ Insurance Company: _____

Group Number: _____ Identification Number: _____

DENTAL HISTORY:

Has the patient ever sucked thumb or finger	Yes No	Does the patient clench or grind teeth	Yes No	Severe head or face injuries	Yes No
Missing adult teeth	Yes No	Extra adult teeth	Yes No	Mouth breather	Yes No
Has had or been treated for TMJ, painful clicking joints	Yes No	Were any teeth removed by extraction	Yes No	Speech problems	Yes No
Any teeth traumatized due to accident	Yes No	Any notable difficulty chewing or swallowing food	Yes No	Other	Yes No

HEALTH HISTORY:

ADHD	Yes No	Use of diet pills/aid	Yes No	Kidney or liver disease	Yes No
Diabetes	Yes No	Disabilities/ Special needs	Yes No	Pregnant	Yes No
Allergies	Yes No	Epilepsy	Yes No	High blood pressure	Yes No
Anemia	Yes No	Fainting	Yes No	Rheumatic fever	Yes No
Autism	Yes No	History of eating disorder	Yes No	Heart Murmur	Yes No
Immune system problems	Yes No	Bone fractures, major injuries	Yes No	Asthma	Yes No
Birth defect(s)	Yes No	Hepatitis	Yes No	Previous surgery	Yes No
Bleeding/clotting problems	Yes No	Prosthetic joints, plates, or pins	Yes No	Endocrine or thyroid problems	Yes No
Vision/speech/hearing problems	Yes No	HIV/AIDS	Yes No	Tuberculosis	Yes No
Depression or mental health disturbance	Yes No	Arthritis or joint problems	Yes No	Cancer, tumor, or radiation treatment	Yes No
Alcohol/ Drug abuse	Yes No	Tobacco use	Yes No	Sickle cell anemia	Yes No

Please explain any "Yes" answers: _____

Is the patient taking any medications at this time: _____

Does the patient have a history of oral bisphosphonates such as Fosamax(alendronate), Actone(ridendronate), Boniva(ibandronate), Skelid(tiludronate), Didronel(etidronate) or IV bisphosphonates such as Zometa(zolendromic acid), or Aredia(pamidronate)? YES NO

RELEASE AND WAIVER: I authorize release of any information regarding the patient's treatment to my dental and/or medical insurance company.

Parent/Guardian Signature: _____ Date: _____

I have read the above questions and understand them. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in completion of this form. I will notify my orthodontist of any changes in the patient's medical or dental health. I consent to an examination and clinical photographs, any necessary x-rays, and dental impressions. I understand there is a fee to receive a copy of any of these materials for outside use.

Parent/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____