PATIENT INFORMATION

WELCOME TO OUR OFFICE! **A B C**

Patient # _____ Patient Age _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birth Date _____ Social Security # _____

If patient is a minor, give parent or guardian's name _____

Patient e-mail address _____

Responsible party e-mail address _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Own or Rent

Previous address (if less than 3 years) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ # years employed _____

Spouse's Name _____
Last First Middle Relationship to Patient

Marital Status _____ Spouse's Social Security # _____

Spouse's Mailing Address _____
Street City State Zip

Spouse's Employer _____ Occupation _____ # years employed _____

Spouse's Birth Date _____ Spouse's Work Phone _____

Spouse's Cell Phone _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

Do you have dual coverage? Yes ( ) No ( ) If yes, please continue: _____

Insured's Name _____ DOB _____ Insured's ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of Nearest Relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

I understand that where appropriate credit bureau reports may be obtained. I understand that I will be responsible for all lab fees incurred in the fabrication of a splint or orthodontic appliance in the event that I choose not to continue treatment. I understand that it is the policy of **Puntillo Orthodontics** that the parent who requests treatment for a minor child shall be responsible for all services rendered.

Signature (Parent's signature if minor) _____ Date _____

E.

Medical History

YES NO

_____ _____ Are you currently under any medical treatment?
If yes, for what?

Who is your physician?_____

_____ _____ Are you currently taking any medications?
If yes, list medications.

_____ _____ Are you allergic to any medications?
If yes, please list.

_____ _____ If you are a woman, are you pregnant?

Have you ever had any of the following? If **yes**, please check.

( ) Heart (Surgery, Disease, Attack)	( ) Ulcers	( ) Hepatitis A (infectious) B (serum)
( ) Chest pain	( ) Diabetes	( ) Venereal Disease
( ) Congenital Heart Disease	( ) Thyroid Problems	( ) A.I.D.S.
( ) Heart Murmur	( ) Glaucoma	( ) H.I.V. Positive
( ) High Blood Pressure	( ) Contact Lenses	( ) Cold Sores / Fever Blisters
( ) Mitral Valve Prolapse	( ) Emphysema	( ) Blood Transfusion
( ) Artificial Heart Valve	( ) Chronic Cough	( ) Hemophilia
( ) Heart Pacemaker	( ) Tuberculosis	( ) Sickle Cell Disease
( ) Rheumatic Fever	( ) Asthma	( ) Bruise Easily
( ) Arthritis / Rheumatism	( ) Hay Fever	( ) Liver Disease
( ) Cortisone Medicine	( ) Latex Sensitivity	( ) Yellow Jaundice
( ) Swollen Ankles	( ) Allergies or Hives	( ) Neurological Disorders
( ) Stroke	( ) Sinus Trouble	( ) Epilepsy or Seizures
( ) Diet (special / restricted)	( ) Radiation Therapy	( ) Fainting or Dizzy Spells
( ) Artificial joints (hip, knee, etc.)	( ) Chemotherapy	( ) Nervous / Anxious
( ) Kidney trouble	( ) Tumors	( ) Psychiatric / Psychological Care

YES NO

_____ _____ Are there any other health problems not listed?

If yes please describe

F.

Dental History

YES	NO	
_____	_____	Do you have a general dentist?
		If yes, print dentist's name._____
		Date of last exam/cleaning._____
_____	_____	If no, would you like us to refer you to a dentist?
_____	_____	Do you have any dental pain or problems needing attention?
		If yes, please describe._____
_____	_____	Do your gums bleed or feel tender?
_____	_____	Have you had gum treatments?
_____	_____	Do you have teeth sensitive to hot / cold / sweets?
_____	_____	Have you had a root canal?
_____	_____	Does food get caught between your teeth?
_____	_____	Are any of your teeth loose?
_____	_____	Have your front teeth separated?
_____	_____	Do you have any missing permanent teeth?
_____	_____	Have you had any permanent teeth extracted?
_____	_____	Do you have a partial plate or complete denture?
_____	_____	If yes, does it fit properly? How old is it?_____
_____	_____	Do you have any high dental fillings, crowns or bridges?

G.

Orthodontic History

YES	NO	
_____	_____	Have you ever had any orthodontic treatment?
		If yes, by whom._____When?_____
_____	_____	Are you unhappy with your facial appearance and profile?
_____	_____	Are you unhappy with the way your teeth look?
_____	_____	Do you feel your bite is changing?
_____	_____	Have you been bumped, traumatized or fractured any teeth?
_____	_____	Do you have any of the following habits?
		(circle) Thumb, finger, lip or pacifier sucking, fingernail biting, biting other objects,
		Other_____
_____	_____	Do you snore?
_____	_____	Is it difficult to breath through your nose?
_____	_____	Do you breath with your mouth constantly open?
_____	_____	Do you have frequent sore throats?
_____	_____	Do you have frequent ear infections or tubes?

Please describe your problem or complaint

H. **TMJ (Jaw Joint) History**

YES	NO	
_____	_____	Do you now or have you ever had a TMJ problem?
_____	_____	If yes, have you ever been treated?
		By whom? Dr._____
		When? Date:_____
_____	_____	Have your teeth ever been ground down?
_____	_____	Do you have jaw joint or facial pain?
_____	_____	Does it hurt to open wide?
_____	_____	Do you have difficulty opening or jaw locking?
_____	_____	Does your jaw pop or click?
		If yes circle one. (Right) (Left) (Both)
_____	_____	Does your jaw make a grinding noise?
		If yes circle one. (Right) (Left) (Both)
_____	_____	Do your ears ring, ache or feel stuffy?
		If yes circle one. (Right) (Left) (Both)
_____	_____	Do you get dizzy frequently?
_____	_____	Do you clench, grind or grit your teeth?
_____	_____	Do your jaws ache or feel tired?
_____	_____	Do your teeth ache in the morning?
_____	_____	Do you have pain or difficulty swallowing?
_____	_____	Do you have a stiff or painful neck?
_____	_____	Has your jaw or chin ever been bumped or hit?
_____	_____	Have you ever had a head, neck, or whiplash injury?
_____	_____	Do you have frequent headaches?
		If yes, circle the correct descriptions.
		Aching, Shooting, Stabbing, Burning or Electrical
		Intensity: (Severe) (Medium) (Light)
		Worse in: (morning) (afternoon) (evening)

Please describe your problem or complaint

I. I represent that all the statements and answers contained herein, are to the best of my knowledge and belief, complete, true and correctly recorded and it is agreed that **Puntillo Orthodontics**, and staff shall not be presumed to have knowledge of any information not so recorded.

Signature:_____ Date:_____

Patient (Parent if Patient is a Minor Child)