DOVORANY
ORTHODONTICS

Orthodontics for Children and Adults

Patient Information

A B C

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Nickname _____ Birthdate _____ Age _____ Sex _____ Social Security # _____

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

Whom may we thank for referring you to 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? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group Number _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

Do you have secondary coverage? (circle one) YES NO If yes: _____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group Number _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone Number _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Update Signature _____ Date

Update Signature _____ Date

DOVORANY
ORTHODONTICS

Orthodontics for Children and Adults

Adult History

Patient Name _____

What is your chief concern for us at this visit? _____

_____

**Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.

Medical History

Y N Are you in excellent health?
Y N Has there been any change in your general health within the last year?
Y N My last physical exam was _____(month/year)
Y N Are you now under the care of a physician? If so, what is being treated? _____
Y N Have you had a serious illness/hospitalization in the past 5 years?
If so, for what? _____
Y N Are you taking any medication (incl. non-prescription)? _____

Do you have any of the following conditions?
Allergies or drug reactions to:

Y N Latex
Y N Penicillin or other antibiotics
Y N Sulfa drugs
Y N Aspirin, Ibuprofen, Tylenol
Y N Local anesthetics
Y N Codeine or other narcotics
Y N Other _____
Y N Respiratory problems, emphysema
Y N Asthma or hay fever
Y N Sinus trouble
Y N Persistent swollen neck glands
Y N Thyroid or endocrine problems
Y N Diabetes
Y N Hepatitis, jaundice or liver disease
Y N AIDS or HIV infection
Y N Sexually transmitted disease
Y N Substance abuse problem (past or present)
Y N Mental health problem or nervous disorder
Y N Fainting spells or seizures
Y N Epilepsy or other neurological disease
Y N Fainting spells or seizures
Y N Blood disorder such as anemia

Y N Abnormal bleeding or blood transfusion
Y N Low blood pressure
Y N Cardiovascular disease (heart trouble, attack, angina, high blood pressure, arteriosclerosis, stroke)
Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease
Y N Arthritis or joint problems or artificial joints/limbs
Y N Require pre-medication before dental visits?
Y N Birth Defects
Y N Kidney trouble
Y N Tuberculosis
Y N Bone fractures or trauma to face or jaw
Y N Vision, hearing or speech difficulty
Y N Persistent Cough
Y N Frequent colds or sore throats
Y N Frequent headaches
Y N Stomach ulcer or hyperacidity
Y N Tumor (Cancerous or benign)
Y N Radiation therapy or Chemotherapy
Y N Females: Are you pregnant?

Y N Do you have any disease, condition or problem not listed above that you think we should know about?

If so, please explain _____

Dental History

Name of patient's dentist_____

Date of last dental exam_____

Y N Chipped or injured permanent teeth
Y N Teeth sensitive to hot or cold
Y N Jaw fractures, cyst, mouth infections
Y N Previous root canal therapy
Y N Bleeding gums or bad taste/mouth odor
Y N Other periodontal (gum) problems
Y N Problems with food trapped between teeth
Y N Frequent canker sores or cold sores
Y N Mouth breathing habit or snoring troubles
Y N Abnormal swallowing (tongue thrust)
Y N Have you had a negative dental experience?

Y N History of missing or extra teeth
Y N Have any permanent teeth been removed?
Y N Have wisdom teeth been removed?
Y N Teeth that irritate tongue, cheek, lip, etc.
Y N Previous orthodontic treatment or retainer
Y N Previous periodontal (gum) treatment
Y N Numerous fillings
Y N Damaged restorations or fillings
Y N Thumb or finger habit as a child
Y N Loose or shifting teeth
Y N Is all dental work completed at this time?

TMJ History

Y N Have you had a TMJ screening?
Y N Do you have a history of jaw joint problems?
Y N Have you been treated for "TMJ"?
Y N Do you grind your teeth?
Y N Do you clench your teeth?
Y N Has your jaw ever locked?
Y N Does your bite feel uncomfortable or unusual?

Y N Do you have pain in your jaw joint?
Y N Do you experience soreness in the muscles of your face or around ears?
Y N Do you notice clicking or popping in your jaw joint?
Y N Do you have difficulty chewing or opening your mouth?

Patient Motivation For Orthodontic Treatment

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (circle the words more, less, forward, etc.)

Teeth - If your teeth could be changed, how would you like them to change?

☐ Straighten the front teeth — upper / lower
☐ Straighten the back teeth — upper / lower
☐ Move upper teeth — forward / backward
☐ Move lower teeth –- forward / backward
☐ Eliminate crowding of teeth — upper / lower
☐ Eliminate spaces between teeth — upper / lower
☐ Make the line of upper teeth more level
☐ Other_____

Face - If your facial appearance could be changed, what would you change?

☐ Move upper lip –- forward / backward
☐ Move lower lip –- forward / backward
☐ Show –- more / less — of my teeth when I smile
☐ Show –- more / less — of my gums when I smile
☐ Reduce the strain in my –- chin / lips — when I close my lips
☐ Make my lips — closer together / farther apart — when my teeth are touching
☐ Make my nose –- longer / shorter
☐ Get rid of sag under lower jaw
☐ Move chin –- forward / backward
☐ Move chin –- left / right
☐ Other_____

Symptoms - If you want to reduce pain or discomfort, please be specific about its location; circle the right or left side or both if they apply.

☐ In front of ears –- right / left
☐ Below ears — right / left
☐ Above ears — right / left
☐ In my ears — right / left
☐ My temples –- right / left
☐ My eyes — right / left
☐ My neck — right / left
☐ My shoulders –- right / left
☐ My jaw joints — right / left
☐ My teeth
☐ My sinuses
☐ Other_____

**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any changes later to this history record or medical or dental status, I will inform the practice.

_____
Signature of Patient Date

_____ _____
Update Signature Date Update Signature Date

_____ _____
Update Signature Date Update Signature Date