

Date _____

Patient Information

Name _____

Last

First

Middle

Sex _____ Age _____ Birthdate _____ Social Security # _____

Address _____

Street

City

Zip

Home Phone _____ Cell Phone _____ E-mail address _____

Employed by _____ Business Phone _____

Spouse's name (if applicable) _____

General Dentist _____ Physician _____

Dental Specialist (i.e. Periodontist, Oral Surgeon, etc) _____

Names of any other family members treated in our office? _____

Whom can we thank for referring you to our office? _____

What are your chief concerns regarding your orthodontic condition? (Overbite, crowding, etc.)

Dental Insurance Information

Insured's Name _____

Insured's Social Security # _____ Insured's Birthdate _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____

Insured's Social Security # _____ Insured's Birthdate _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Medical History

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?

Yes No Are you allergic to any medication?

Yes No Are you allergic to metals (i.e. nickel) or latex?

Yes No Do you have a history of a major illness?

Yes No Have you had any major operations?
Yes No Have you ever been involved in a serious accident?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

Dentist _____ Date of last visit _____

Yes No Have you ever seen an orthodontist? If yes, who and when?
Yes No Do you/would you have any problems chewing gum?
Yes No Do you/would you have any problems chewing bagels or other hard foods?
Yes No Have your teeth changed in the last 5 years, become shorter, thinner, or worn?
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes No Are you aware of your jaw clicking or popping?
Yes No Are you aware of clenching your teeth?
Yes No Have you ever been told that you grind your teeth?
Yes No Do you have "tension" headaches?
Yes No Have you ever experienced chronic ringing in your ears?
Yes No Are you presently in any dental pain?
Yes No Have you ever experienced any unfavorable reaction to dentistry?
Yes No Have you ever lost or chipped any teeth?
Yes No Have you ever had any facial or dental injuries?
Yes No Are your teeth crowding or developing spaces?
Yes No Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?
Yes No Do you have any problems with sleep or wake up with an awareness of your teeth?
Yes No Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
Yes No Do you have tension headaches or a history of migraines?
Yes No Are you currently experiencing any dental pain or sore teeth?
Yes No Have there been any injuries to face, mouth or teeth?
Yes No Is any part of your mouth sensitive to temperature or pressure?
Yes No Do your gums bleed when you brush?
Yes No Do you wear or have you ever worn a bite appliance?

Please note any other factors that are relevant to your dental health. _____

Authorization

I authorize the release of medical and dental information to insurance carriers, other health care providers in my dental care, and the use of records by Dr. Rosenzweig for teaching purposes or scientific publication.

In the future, please advise the doctor of any changes in your medical or dental health while under care in this office.

Signature: _____ Date: _____