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FOR OFFICE USE ONLY

- ☐ Records Date _____
- ☐ Minus Panorex, obtain from GP
- ☐ WCB
- ☐ Double Pour
- ☐ Upper Impression
- ☐ Recall _____months
- ☐ Second Consult with Panorex
- ☐ Request original records
- ☐ CP with outside records
- ☐ Lower Impression

Date _____ Nickname _____

Patient's Full Name _____ Soc. Sec. # _____

Birthdate _____ Age _____ Male _____ Female _____

Home Address _____ Home Phone _____ Cell _____

City _____ State _____ Zip _____

(If Adult) Employed By _____ Email Address _____

Business Address _____ Position _____

Cell Phone _____ Business Phone _____

Father's (Husband's) Name _____ Soc. Sec. # _____

Employed By _____ Position _____

Business Address _____ Business Phone _____

Mother's (Wife's) Name _____ Soc. Sec. # _____

Employed By _____ Position _____

Business Address _____ Business Phone _____

Person responsible for this account _____

Billing Address (if different from home address) _____

_____

Do you have Orthodontic Dental Insurance? Yes____ No____ Insured Name _____

Name of Insurance Co. _____ Group # _____

Patient's Dentist _____ Patient's Physician _____

School Attending (if minor) _____ Musical Instrument Played _____

Hobbies/Sports _____

Brothers/Sisters _____

Has patient had a previous orthodontic consultation? No____ Yes____ With Who _____

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

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Please complete reverse side →

x _____

Dr. Louis C. Filippone

MEDICAL

		YES	NO
1.	Is the patient in good health?		
2.	Has there been any change in general health in the past year?		
3.	Is the patient presently under a physician's care?		
4.	Has the patient ever been seriously ill?		
5.	Has the patient ever been hospitalized?		
6.	Has the patient ever had surgery?		
7.	Is the patient currently taking any medication?		
	If yes, which medication? _____		
8.	Does the patient need to be pre-medicated with antibiotics before a dental visit?		
9.	Has the patient taken Bisphosphonates in the last twelve years?		

10. Is there an history of the following?	YES	NO		YES	NO
Current Heart Murmur			Any joint problems		
Heart valve replacement			Joint replacement		
Severe headaches			Orthopedic surgery		
Sinus trouble			Heart disease		
Frequent colds and sore throats			High blood pressure		
Persistent cough			Hepatitis		
Tonsilitis			Liver disease		
Operation or injury to teeth or jaws			Kidney disorder		
Deviated Septum of nose			Diabetes		
Allergies			Endocrine disturbance		
(Name them)			Convulsions		
Anemia			Venereal disease		
Bleeding Problem			Acquired Immune Deficiency		
Tuberculosis			HIV Infection		
Asthma			Emotional problem		
ADD or ADHD			Do you smoke		
Rheumatic fever			Other		
Cancer			Current Pregnancy		
Snoring			Sleep apnea		
Cleft lip and palate			Thyroid Disorder		

GROWTH AND DEVELOPMENT

IF PATIENT IS A MINOR ANSWER 11-15

		YES	NO
11.	Have tonsils or adenoids been removed?		
12.	Has the patient experienced a sudden increase or decrease in growth?		
13.	If a male, has the patient started to shave?		
	Has his voice changed?		
14.	If a female, has the patient started to menstruate?		
15.	Is your child's physical development with his age group?	_____ Earlier	_____ Later _____ On time

DENTAL

16. When did the patient last see the dentist? _____

17. Is there a history of the following?	YES	NO		YES	NO
Removal of teeth			Root Canal		
Sensitive teeth			Oral surgery		
Sore, bleeding gums			Other extensive treatment		
Gum chewing			Trauma to teeth or jaws		

Please explain _____

18. Is there a history of the following habits?	YES	NO		YES	NO
Thumbsucking			Nail/lip biting		
Fingersucking			Tongue thrust swallow		
Mouth breathing			Speech problems		

		YES	NO
19.	Does the patient grind the teeth or clench the jaws at night?		
	During the day?		
20.	Does the patient breathe mainly through the mouth at night?		
21.	Is there clicking or popping of the lower jaw joint?		
22.	Is there pain or ache of the lower jaw joint at any time?		
23.	Why are you seeking treatment?		

All patients are required to have a dental exam & cleaning, oral pathology exam and periodontal exam by a dentist before orthodontic treatment and should see their dentist every six months. It is the patient's responsibility to inform this office of any changes to their Medical history.

Signature (Parent's signature if minor) _____