**LOUIS C.FILIPPONE, D.D.S., P.C.**

*Specialist in Orthodontics and Dentofacial Orthopedics*

*BOARD CERTIFIED 01PLOMATE AMERICAN BOARD OF ORTHODONTICS*

(703) 815-0127 EMAIL [orthoforyou@aol.com](mailto:orthoforyou@aol.com) (703) 754-4880

*FOR OFFICE USE ONLY*

D Records Date \_ D Minus Panorex, obtain from GP D WCB

D Double Pour

D Upper Impression

D Recall months

D Second Consult with Panorex D Request original records

D CP with outside records D Lower Impression

Date \_

Patient's Full Name \_ Birthdate Age \_ Home Address \_ Cicy \_

(If Adult) Employed By \_

Nickname \_ Soc.Sec. # \_ Male F. emale \_ Home Phone Cell \_

State Zip \_

EmailAddress \_

Business Address \_ \_

Position

\_\_

Cell Phone \_

Business Phone \_

### Father's (Husband's) Name

\_ Soc.Sec.# \_ \_\_

Employed By \_ Business Address. \_

Mother's (Wife's) Name \_ Employed By \_

Business Address \_ Person responsible for this account \_

Position \_ Business Phone \_

### Soc.Sec.# \_

Position \_ Business Phone \_

### \_\_

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 Pfayed \_\_ \_\_

### HobeslSports \_

Brothers/Sisters\_

Has patient had a previous orthodontic consultation? No Yes

\_

### With Who \_ \_

Whom may we thank for referring you to our office? \_ \_

\_\_\_

*FOR OFFICE USE ONLY*

Please complete reverse side -+ x. \_\_ \_\_

Dr.Louis C. Filippone

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | **MEDICAL**  Is the patient in good health?.•• • • ..•• .• • • • • • • • • • • • .•• • • .•• .•..• ..•.•......• ..•.....• .•• • • .• .• ...• .. | YES | NO |
| 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? • • • • • .•.•.•....• • • • • .• .•• .•.•• • • • • ........•• • • .....•.... |  |  |
| 8. | If yes,which medication? --------------------------------- 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? Current Heart Murmur..•• • • • • • • • • • • • • • • • • •

Heart valve replacement.• ..•...•• .•• • • • .•. Severe headaches...•• • • • • • .•.•..•• • • • .•. Sinus trouble .• • • • • • • • • • .•• • • • • • ..•.•• • .. Frequent colds and sore throats • • • .•..• • • • • Persistent cough • • • ...•• • • • • • ..• .•.• .•• • • Tonsilitis .• .•.• .•• • • • .•.•.....• • .•.• .• .•. Operation or injury to teeth or jaws .• • • • • • • • . Deviated Septum of nose • .•• • • .• • .• • ..•• .. Allergies • .• .• • • • • • • • ....•• • • • • • • • .• .•• • • (Name them)

Anemia..• ..•• • • • • • ..•..•• .• .•• • • • • • • • .• Bleeding Problem • • • • • • • • • .• .•• • • • • • • • • • . Tuberculosis.• • • • .• • • • • • .• .•• • .•• • • • .•• • . Asthma.• • • .• .• ..•• • • • • • • • • ..•..• .•• • • • . ADD or ADHD ..•.•.•.• .• .• • • • • • ..•..• .•• Rheumatic fever • • • • • • .•• • • • • • .• • • • .•• • • • Cancer .•• • • • .•.•.•.• • • • • • • • • .•.•• • • • • • • Snoring.• ..•• • • ...• .•• .•..• • • .•• ..•.•• • . Cleft lip and palate • • • • • • • • • .•• • ..•• • • • • • .

YES NO

Any joint problems ...•• • • • .•• ....•• • • • • .• Joint replacement .• .• ....•.•• • • • ...•• • .•• Orthopedic surgery ....•......•.•• • .•• • ..•

Heart disease• • • • • .•......• .• • .•.•...•...

High blood pressure • • • .•.....•• • • • ...•... Hepatitis....•• ....•• ..•.•......•• • ..•...

Liver disease ...• • .•• ..•.•.• .•....•..•...

Kidney disorder ..•.•.....•.•.•.•..• .•.•..

Diabetes ..........• • • • ........•.•• • • .•.. Endocrine disturbance ..•• .• .• ....•.•• • .•. Convulsions • ....• .•• • • • .• .•..• .• .•• .•• • .

Venereal disease • ..•.•.•.•.• .•• ........•. Acquired Immune Deficiency • • • • .• ...•• • • • • HIV Infection • .•• • • .•....•.•• • • • .•......•

Emotional problem .....•• ...•......•.•.•.

Do you smoke • • • • .•......•.•• • • ...•.•• • . Other .......• .• • • • .•.•.•....•• • .....•• . Current Pregnancy ..• • • • .•........•• • .• ..

Sleep apnea.• .•• ....•• ......•• • • ..• .•• ..

Thyroid Disorder .......•...•.•.•• • • • • ..••

YES NO

# GROWTH AND DEVELOPMENT

*IF PATIENT IS A MINOR ANSWER 11-15*

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? • • .•..•..•.•.•.•.•.•• ............•• • .•• • .............

YES NO

15. Is your child's physical development with his age group?

# DENTAL

Ear1ier

Later

On time

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

17. Is there a history of the following? Removalof teeth• .•.•..•.•• • • • • • • .•• . Sensitive teeth.•• ...•• • .•..•• • .• .•.•• Sore, bleeding gums .•• • • • • • • • • • • • • • • • Gum chewing • • • • .•• • • • • .•• ..•.• • • • •

YES NO

Root Canal. • • ...•• • .•.•........• • ...•.•.

Oral surgery• ...•.• ..•.•.•.•...•.....•... Other extensive treatment • • • • .•• • .•• .•.• • • Trauma to teeth or jaws ..• .•• .•• • • • • .....•

YES NO

Please explain ---------------------------------------------

1. Is there a history of the following habits? Thumbsucking..•• • .•.•.•• • • .• .• .•• • . Fingersucking • • • • ..•• .• .•• • • • • • • • • • . Mouth breathing • • .• .•• • .• • • • • • • • • • • •

YES NO YES NO

Nail/lip biting ....•..• • • • .•.•......•• • • .•. Tongue thrust swallow • • • • • .•...•..•• .•• • • Speech problems .....• ...• .•• .....•...••

1. Does the patient grind the teeth or clench the jaws at night?• .• • • .•• .•.• • • ...•• ......•.•.•.• ....• .•.• ..•.

During the day?.• ....•• • .•.•.• .............•• ..•....•..••

1. 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. Hls the patient's responsibility to inform this office of any changes to their Medical history.

Signature (Parent's signature if minor)

\_\_\_\_

\_\_\_\_\_