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CONFIDENTIAL
Patient is under 18 years of Age

Date_____ Computer Number_____

Patient's Last Name: _____First Name:_____Middle Initial:_____

Birth Date:_____/_____/_____Age:_____Sex: M / F I prefer to be called: _____

Patient's Address_____

City:_____State/Province:_____Zip:_____

Home Phone:_____Cell:_____

E-Mail Address_____

School:_____Grade:_____

Any family member or friends treated here:_____

Mother's Name:_____

Work Phone:_____Cell Phone:_____

Address (if different): _____

Occupation:_____S.S.N.:_____

Father's Name:_____

Address (if different): _____

Work Phone:_____Cell Phone:_____

Occupation:_____S.S.N._____

Name of Patient's Dentist:_____

Date last seen:_____Reason:_____

Name of Patient's Physician:_____Office Phone:_____

Date last seen:_____Reason:_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:_____

Who is financially responsible for this account?

Last Name:_____First Name:_____Middle Initial:_____

Address(if different):_____

City:_____State/Province:_____Zip_____Phone:_____

Work Phone:_____S.S.N.:_____or ID number:_____

Birth Date:_____/_____/_____ E-mail Address:_____

Do you have Dental Insurance?_____

THE FOLLOWING QUESTIONS MARK YES OR NO. THE ANSWERS ARE FOR OFFICE RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

Patient Profile

___yes ___no Does patient follow directions well?

___yes ___no Does patient have a learning disability?

___yes ___no Does patient brush teeth conscientiously?

___yes ___no Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, have you had:

___yes ___no Rheumatoid or arthritic conditions?

___yes ___no Endocrine or Thyroid problems?

___yes ___no Diabetes?

___yes ___no Cancer, tumor, radiation treatment or chemotherapy?

___yes ___no Immune system problems?

___yes ___no AIDS or HIV?

___yes ___no Hepatitis, jaundice, or liver problems?

___yes ___no Mental health disturbances or depressions?

___yes ___no Vision, hearing, tasting, or speech difficulties?

___yes ___no History of eating disorder (anorexia, bulimia)?

___yes ___no High or low blood pressure? (Circle one)

___yes ___no Heart problems?

___yes ___no Skin disorder?

___yes ___no Frequent headaches?

___yes ___no Eye, ear, nose, or throat condition?

___yes ___no Hay fever, asthma, sinus trouble?

___yes ___no Tonsil, or adenoid condition?

___yes ___no Osteoporosis?

Allergies or reactions to any of the following:

___yes ___no Local anesthetics

___yes ___no Aspirin

___yes ___no Ibuprofen

___yes ___no Penicillin or other antibiotics

___yes ___no Vinyl

___yes ___no Acrylic

___yes ___no Other Substances

___yes ___no Latex (gloves, balloons)

___yes ___no Codeine or other narcotics

___yes ___no Metals (jewelry, clothing snaps)

OTHER

___yes ___no Do you currently have or ever had a substance abuse problem?

___yes ___no Do you, or have you chewed or smoked Tobacco? If so, when?_____

___yes ___no Other physical problems or medical conditions?

_____

_____

MEDICATIONS

Have you ever taken Biphosphanate Drugs for Cancer, Osteoporosis or any other condition? _____yes_____no If yes, which one(s):

IV _____Aredia

_____Zometa

_____Other

ORAL_____Actinel

_____Boniva

_____Didronel

_____Skelid

_____Other

OTHER MEDICATION(S) TAKEN:

Medication_____taken for_____

Medication_____taken for_____

Medication_____taken for_____

Medication_____taken for_____

Do you ever take a Pre-Medication antibiotic before certain dental procedures? _____yes _____no

Continue from page 2,

DENTAL HISTORY

Now or in the past have you ever had?

___yes ___no _____date Supernumerary “extra” permanent teeth removed?

___yes ___no _____date Chipped or otherwise injured primary or permanent teeth?

___yes ___no _____date Teeth sensitive to hot, or cold: teeth throb or ache?

___yes ___no _____date Jaw fractures, cysts or mouth infections?

___yes ___no _____date Periodontal “gum problems”?

___yes ___no _____date History of speech problems?

___yes ___no _____date Mouth breathing habit?

___yes ___no _____date Tooth grinding or jaw clenching?

___yes ___no _____date Would you mind wearing braces?

___yes ___no _____date Any serious trouble with any previous dental treatment?

___yes ___no _____date Ever had an orthodontic evaluation or treatment? If yes, who provided the examination or ortho?

_____

___yes ___no _____date Been under another specialist care (Periodontist, Endodontist, etc…)?

___yes ___no _____date Thumb, finger, or sucking habit? Age habit ceased?_____

___yes ___no _____date Tongue thrusting?

___yes ___no Has any relative ever had jaw surgery to correct their bite?

___yes ___no Does any relative have an under bite?

How often does your child brush? _____Floss? _____

What is your primary concern? Why are you here? _____

I have read and understood the above questions. I will not hold the orthodontist or any other member of his/her staff responsible for any errors or omissions that I have made in the completions of this form. If there are any changes later to this history record or medical/dental status, I will so inform the office. I also understand that in order to offer financial arrangements it is necessary to gather credit information.

Signed: _____Date signed: _____
Parent or Guardian

HIPAA ACKNOWLEDGEMENT

I have been notified and I acknowledge the Notice of Privacy Practice for Drs. Gary and Jonathan Shanker and Dr. Brian Schlueter’s office. I have been offered a copy to take with me.

_____
Initials