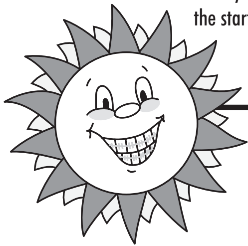

Michele A. Bernardich DMD, MSD

Orthodontics for Children and Adults

Member
American Association of
Orthodontists

WELCOME TO THE ORTHODONTIST

We would like to welcome you to our office. Our goal is to make your visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOURSELF

Today's Date: ______________________

Name: ______________________

Nickname: ______________ ☐ Male ☐ Female

Birthdate: ______________ Age: ________

Social Security Number: ______________________

Hobbies/Sports: ______________________

Home Phone #: ______________________

Home Address: ______________________

____

Employer: ______________________

Occupation: ______________________

Work #: ______________ Ext.: ________

Whom may we thank for referring you? ______________

Family Physician: ______________ Last Physical ________

General Dentist: ______________ Last Visit: ________

How often does pt. brush: ______________ Floss: ________

Marital Status: ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

SPOUSE INFORMATION

Name: ______________________

Birthdate: ______________________

Social Security Number: ______________________

Employer: ______________________

Occupation: ______________________

Work #: ______________ Ext.: ________

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: ☐ Yes ☐ No

Lifetime Benefit: ______________ Amount Used: ________

Insurance Company Name: ______________________

Insurance Company Address: ______________________

____

Phone #: ______________ Group #: ______________

Name of Insured: ______________________

Relationship to Patient: ______________________

Insured's Birthdate: ________ S.S. #: ______________

Insured's Employer: ______________________

SECONDARY ORTHODONTIC INSURANCE

Lifetime Benefit: ______________ Amount Used: ________

Insurance Company Name: ______________________

Insurance Company Address: ______________________

____

Phone #: ______________ Group #: ______________

Name of Insured: ______________________

Relationship to Patient: ______________________

Insured's Birthdate: ________ S.S. #: ______________

Insured's Employer: ______________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________

Relation: ______________________

Billing Address: (if different):

____

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N AIDS/ARC/HIV+
Y N Allergies List ______________________________
Y N Anemia
Y N Artificial Joints/Bone Pins
Y N Asthma/Hayfever/Sinus Trouble
Y N Birth Defects
Y N Bone Fractures
Y N Diabetes
Y N Endocrine or Thyroid Problems
Y N Epilepsy, Seizures, Fainting spells
Y N Excessive Bleeding/Blood Diseases
Y N Handicaps/Disabilities
Y N Headaches (severe, frequent)
Y N Head Injuries
Y N Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arterlosclerosis, stroke, inborn heart defects or rheumatic heart)
Y N Heart Murmur
Y N Hearing Problems/Disorders
Y N Hepatitis, Jaundice, Liver Disease
Y N Low/High Blood Pressure
Y N Kidney Disease
Y N Mental Problems or Behavioral Problems
Y N Mitral Valve Prolapse
Y N Nerve Disorders
Y N Eye, Ears, Nose and Throat conditions
Y N Respiratory Treatment
Y N Rheumatic Fever/Scarlet Fever
Y N Rheumatism, Arthritis
Y N Substance abuse problem (current or past)
Y N Stroke
Y N Stomach Ulcer
Y N Tuberculosis, Polio, Mono or Pneumonia
Y N Sexually transmitted diseases
Y N Cancer/Chemotherapy/Radiation Therapy
Y N Are you in good physical health?
Y N History of any major illnesses or operations?

List ____

____

List current medications, nutrient supplements or non prescription drugs ______________________________

Female Patient

Y N Are you pregnant?
Y N Are you taking birth control pills?
Y N Are you anticipating becoming pregnant?

Doctor's Comments: ______________________________

____

____

____

DENTAL HISTORY

Y N Chipped or otherwise injured permanent teeth?
Y N Teeth sensitive to hot or cold; teeth throb or ache?
Y N Jaw fractures, cysts, mouth infections?
Y N "Dead Teeth", root canals treated?
Y N Bleeding gums, bad taste, mouth odor?
Y N Periodontal "Gum problems"?
Y N Food impaction between teeth?
Y N "Gum Boils", frequent canker sores, cold sores?
Y N Thumb, finger, sucking habit? Until ______________
Y N Abnormal swallowing habit (tongue thrusting)?
Y N Mouth breathing habit, snoring, difficulty in breathing?
Y N Tooth grinding, jaw clenching, clicking, locking?
Y N Do you experience any pain or soreness in the muscles of your face, or around the ears?
Y N Any pain in jaw or ringing in the ears?
Y N Have you ever been treated for "TMJ" problems (jaw joint and facial muscle pain)?
Y N Difficulty encountered in chewing or jaw opening?
Y N History of supernumerary (extra) or congenitally missing teeth?
Y N Have any permanent teeth been removed?
Y N Aware of loose, broken or missing restorations (fillings)?
Y N Any teeth irritating cheek, lip, tongue, palate?
Y N Have you ever had Orthodontic treatment or worn a "retainer" or "bite plate"?
Y N Have you recently been under another dentist's care? Specialist ______________________________
Y N Have you ever had Periodontal (gum) treatment?
Y N Concerned about spaced, crooked, protruding teeth?
Y N Aware or concerned about under or over developed jaw?
Y N Any relative with similar tooth or jaw relationships?
Y N Have you had any serious trouble associated with any previous dental treatment?

What is your primary concern - Why are you here? __________

____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

____
Signature of patient Date

I verbally reviewed the medical/dental information above with the patient named herein.

Initials: ________ Date: __________

Date: ___________________________

Health Changes ______________________________________

____

____

Patient's Signature ____

CURRENT MEDICATIONS

1. ____
2. ____
3. ____

Staff Initials ____________________