CURTIS & BARYSENKA Sycamore ORTHODONTICS

1) ABOUT YOU

Today's Date:_____

Your Name: _____

I prefer to be called: _____

☐ MALE ☐ FEMALE DATE OF BIRTH ____/____/____

Age: _____SS#: _____

Home Address: _____

_____

☐ SINGLE ☐MARRIED ☐ DIVORCED

☐ WIDOWED ☐SEPARATED

Cell#(___) _____ Email:_____

Employer: _____

Employer Address: _____

Occupation: _____How long there: _____

When are the best times to reach you? _____

Whom may we thank for referring you? _____

_____

Other family members seen by us: _____

_____

General Dentist: _____

Date of Last Visit: _____

2) Spouse Information

His/Her Name: _____

Employer: _____

Wk#:_____ext.___DOB ___/___/____

Person Responsible for Account: _____

Address: _____

Phone number: (_____) _____

3) ORTHODONTIC INSURANCE

Orthodontic Coverage ☐Y☐N Dental Coverage ☐Y☐N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone#: (___) _____

Subscriber # or Member ID#: _____

Group #: _____Policy Holder's DOB ___/___/____

Policy Holder's Name: _____

Policy Holder's SS # _____

Policy Holder's Employer: _____

Relationship to Policy Holder if not yourself: _____

Secondary Insurance Policy

Orthodontic Coverage ☐Y☐N Dental Coverage ☐Y☐N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone#: (___) _____

Subscriber # or Member ID#: _____

Group #: _____Policy Holder's DOB ___/___/____

Policy Holder's Name: _____

Policy Holder's SS # _____

Policy Holder's Employer: _____

Relationship to Policy Holder if not yourself: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____Relation:_____

Wk#(____) _____Cell # (_____)_____

4) MEDICAL HISTORY

Physician's Name: _____

Phone:(___)_____Date of last visit:___/___/____

Your current physical health is? ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

N

Are you taking any prescription/over the counter drugs? ☐ Y ☐ N

Please list each one: _____

For Women: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week # _____

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following:

Abnormal Bleeding ☐Y☐N	Diabetes ☐Y☐N
Hepatitis ☐Y☐N	Handicaps/Disabilities ☐Y☐N
Artificial Bones/Joins/Valves ☐Y☐N	Hearing Impairment☐Y ☐N
Allergic to plastics ☐Y☐N	Heart Murmur ☐Y☐N
Any hospital stays ☐Y☐N	Hemophilia ☐Y☐N
Asthma/Arthritis ☐Y☐N	HIV/AIDS ☐Y ☐N
Cancer/Chemotherapy ☐Y☐N	Kidney/Liver Problems ☐Y☐N
Congenital Heart Defect ☐Y ☐N	Tuberculosis ☐Y ☐N
Rheumatic/Scarlet Fever☐Y☐N	Epilepsy/Seizures/Fainting ☐Y☐N
Anemia☐Y☐N	Mitral Valve Prolapse ☐Y☐N
Blood Transfusion ☐Y☐N	Psychiatric Problems ☐Y☐N
Difficulty Breathing ☐Y☐N	Radiation Treatment ☐Y☐N
Drug/Alcohol Abuse ☐Y☐N	Emphysema ☐Y☐N
Severe/Frequent Headaches ☐Y☐N	Shingles ☐Y☐N
Sickle Cell Disease/Traits ☐Y☐N	Fever Blisters/Herpes ☐Y☐N
Glaucoma ☐Y☐N	Sinus Problems ☐Y☐N
Heart Attack/Stroke ☐Y☐N	Ulcers/Colitis ☐Y☐N
Heart Surgery/Pacemaker ☐Y☐N	Venereal Disease ☐Y☐N

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following:

Aspirin ☐Y☐N Dental Anesthetics ☐Y☐N Penicillin ☐Y☐N

Any Metals/Plastics ☐Y☐N Erythromycin ☐Y☐N Latex ☐Y☐N

Codeine ☐Y☐N Tetracycline ☐Y☐N

Please list any other drugs/materials that you are allergic to: _____

_____

5) DENTAL HISTORY

What are the main concerns that you would like Orthodontics to accomplish?_____

_____

_____

Have you ever had or been evaluated for Orthodontic Treatment?☐ Y ☐

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ/TMD)? ☐ Y ☐ N

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Gums ever bleed? ☐ Y ☐ N

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems? ☐Y☐N _____

Do you generally breathe through your mouth? ☐Y☐N

If yes, please circle While Awake While Asleep

Do you have any missing or extra permanent teeth? ☐Y☐N

Have you ever taken Phen-Fen? (Redux or Pondimin) ☐Y☐N

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, will be held in the strictest confidence, and is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature

_____

Date