WELCOME TO NORTH JERSEY ORTHODONTICS

MEDICAL AND DENTAL HISTORY

*Patient Information

Name ____

SS# _____________________ Date of Birth _________________ Age ______________________

Address ____

E-Mail Address____

Check One: Single ______ Married ______ Divorced ______ Separated ______ Widowed _________

Home Telephone Number: _______________Work Telephone Number ________________________

Occupation ____

General Dentist _____________________________________ Date of Last Visit ________________

Physician's Name ______________________________________ Date of Last Visit _____________

Whom may we thank for referring you? ____

*Medical History

Y N Heart Attack/Stroke

Y N Cancer/Chemotherapy

Y N Heart Murmur

Y N Rheumatic Fever

Y N HIV+/AIDS

Y N Heart Surgery/Pacemaker

Y N Shingles

Y N Mitral Valve Prolapse

Y N Kidney Problems

Y N Psychiatric Problems

Y N Epilepsy/Seizures/Fainting Spells

Y N Diabetes/Tuberculosis (TB)

Y N Drug/Alcohol Abuse

Y N Venereal Disease

Y N Hemophilia/Abnormal Bleeding

Y N Ulcers/Colitis

Y N Congenital Heart Defect

Y N Anemia/Radiation Treatment

Y N	Artificial Joints/Bones	Y N	Asthma/Arthritis
Y N	Artificial Valves	Y N	Difficulty Breathing
Y N	Sinus Problems	Y N	Hospitalized for Any Reason
Y N	High/Low Blood Pressure	Y N	Hepatitis
Y N	Fever Blisters	Y N	Blood Transfusion
Y N	Severe/Frequent Headaches	Y N	Emphysema/Glaucoma

Are you taking any prescription/over-the-counter drugs? (Circle one) Yes No

Please list each one: ____

Please list any drugs you are allergic to:

____

*Dental History

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

____

Have you ever been treated or evaluated for orthodontic treatment? Y N

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

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you had injury to your (Circle one): Mouth Teeth Chin

Do you have any speech problems?

____

Do you generally breathe through your mouth? Y N

Awake Y N

Asleep Y N

Do you have any missing or permanent teeth missing teeth? Y **N**

Insurance Information

Employer:
____

Employer's Address
____

Insurance Company Name:
____

Address:
____

Insurance Company Telephone Number: _________________________ Group Number: ___________

Secondary Insurance: Yes __________ No __________ (if no, please skip next section)

Secondary Insurance Company Name:
____

Address: ____

Telephone Number: __________________________________ Group Number: ___________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it 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 with my informed consent that I may need during diagnosis and treatment.

X ____

Signature