Schantz & Moranda
Orthodontic Care
A Dental Corporation
www.desertbraces.com

ADULT Confidential Patient Information

Date _____

Patient's Name _____ (Last / First / Middle)

Address _____ (Street / City / State / Zip)

Home Phone _____ Birthdate _____ Age _____ Social Security # _____

General Dentist _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

A B C

Name _____ (Last / First / Middle) Marital Status _____

Residence _____ (Street / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip)

Social Security # _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last / First / Middle)

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____

Policy Holder's Employer _____

Do you have dual coverage? No ☐ Yes ☐ If yes: _____

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

WOMEN ONLY

☐ yes ☐ no ☐ dk/u Are you pregnant?

☐ yes ☐ no ☐ dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain:

Bleeding disorders_____

Diabetes_____

Arthritis_____

Severe allergies_____

Unusual dental problems_____

Jaw size imbalance_____

Any other family medical conditions that we should know about?

_____

_____

DENTAL HISTORY

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Permanent or "extra" (supernumerary) teeth removed?

☐ yes ☐ no ☐ dk/u Supernumerary (extra) or congenitally missing teeth?

☐ yes ☐ no ☐ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

☐ yes ☐ no ☐ dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐ yes ☐ no ☐ dk/u Jaw fractures, cysts or mouth infections?

☐ yes ☐ no ☐ dk/u "Dead teeth" or root canals treated?

☐ yes ☐ no ☐ dk/u Bleeding gums, bad taste or mouth odor?

☐ yes ☐ no ☐ dk/u Periodontal "gum problems"?

☐ yes ☐ no ☐ dk/u Food impaction between teeth?

☐ yes ☐ no ☐ dk/u "Gum boils," frequent canker sores or cold sores?

☐ yes ☐ no ☐ dk/u Thumb, finger, or sucking habit? Until what age_____?

☐ yes ☐ no ☐ dk/u Abnormal swallowing habit (tongue thrusting)?

☐ yes ☐ no ☐ dk/u History of speech problems?

☐ yes ☐ no ☐ dk/u Mouth breathing habit, snoring or difficulty in breathing?

☐ yes ☐ no ☐ dk/u Tooth grinding or jaw clenching?

☐ yes ☐ no ☐ dk/u Any pain, clicking or locking in jaw or ringing in the ears?

☐ yes ☐ no ☐ dk/u Any pain or soreness in the muscles of the face or around the ears?

☐ yes ☐ no ☐ dk/u Difficulty in chewing or jaw opening?

☐ yes ☐ no ☐ dk/u Have you ever been treated for "TMD" or "TMJ" problems?

☐ yes ☐ no ☐ dk/u Aware of loose, broken or missing restorations (fillings)?

☐ yes ☐ no ☐ dk/u Any teeth irritating cheek, lip, tongue or palate?

☐ yes ☐ no ☐ dk/u Concerned about spaced, crooked or protruding teeth?

☐ yes ☐ no ☐ dk/u Aware or concerned about under or over developed jaw?

☐ yes ☐ no ☐ dk/u Any relative with similar tooth or jaw relationships?

☐ yes ☐ no ☐ dk/u Any wisdom tooth problems?

☐ yes ☐ no ☐ dk/u Had periodontal (gum) treatment?

☐ yes ☐ no ☐ dk/u Had any serious trouble associated with any previous dental treatment?

☐ yes ☐ no ☐ dk/u Been under another dentist's care?

Specialist_____

Other_____

☐ yes ☐ no ☐ dk/u Ever had a prior orthodontic examination or treatment?

☐ yes ☐ no ☐ dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush: _____ Floss: _____

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

I have read and understand the above questions. I will not hold any 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.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

CONFIDENTIAL (for record and pretreatment evaluation)

For the following questions, mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Now or in the past, have you had:

☐ yes ☐ no ☐ dk/u Birth defects or hereditary problems?
☐ yes ☐ no ☐ dk/u Bone fractures, any major accidents?
☐ yes ☐ no ☐ dk/u Rheumatoid or arthritic conditions?
☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?
☐ yes ☐ no ☐ dk/u Kidney problems?
☐ yes ☐ no ☐ dk/u Diabetes?
☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Stomach ulcer or hyperacidity?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐ yes ☐ no ☐ dk/u Problems with the immune system?
☐ yes ☐ no ☐ dk/u AIDS or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or liver problems?
☐ yes ☐ no ☐ dk/u Fainting spells, seizures, epilepsy or neurological problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
☐ yes ☐ no ☐ dk/u Vision, hearing, tasting or speech difficulties?
☐ yes ☐ no ☐ dk/u Loss of weight recently, poor appetite?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Tired easily?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath or swelling ankles?
☐ yes ☐ no ☐ dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐ yes ☐ no ☐ dk/u Skin disorder?
☐ yes ☐ no ☐ dk/u Do you have a well-balanced diet?
☐ yes ☐ no ☐ dk/u Frequent headaches, colds or sore throats?
☐ yes ☐ no ☐ dk/u Eye, ear, nose or throat condition?
☐ yes ☐ no ☐ dk/u Hayfever, asthma, sinus trouble or hives?
☐ yes ☐ no ☐ dk/u Tonsil or adenoid conditions?
☐ yes ☐ no ☐ dk/u Osteoporosis?

Allergies or reactions to any of the following:

☐ yes ☐ no ☐ dk/u Local anesthetics (Novocaine or Lidocaine)
☐ yes ☐ no ☐ dk/u Aspirin
☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)
☐ yes ☐ no ☐ dk/u Penicillin or other antibiotics
☐ yes ☐ no ☐ dk/u Sulfa drugs
☐ yes ☐ no ☐ dk/u Codeine or other narcotics
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Vinyl
☐ yes ☐ no ☐ dk/u Acrylic
☐ yes ☐ no ☐ dk/u Animals
☐ yes ☐ no ☐ dk/u Foods (specify)_____
☐ yes ☐ no ☐ dk/u Other substances (specify)_____

_____

☐ yes ☐ no ☐ dk/u Are you currently taking or have you ever taken intravenous bisphosphonates for serious bone disorders/cancers, such as Zometa (zolendronic acid), Aredia (pamidronate), Didronei (etidronate)?

☐ yes ☐ no ☐ dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate)? Please name the medication and length of time on the medication.

Medication_____ Length of time taken_____
Medication_____ Length of time taken_____

☐ yes ☐ no ☐ dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them:

Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____

☐ yes ☐ no ☐ dk/u Do you currently have or ever had a substance abuse problem?
☐ yes ☐ no ☐ dk/u Do you chew or smoke tobacco?
☐ yes ☐ no ☐ dk/u Operations? Describe:_____

_____

☐ yes ☐ no ☐ dk/u Hospitalized? Describe:_____

_____

☐ yes ☐ no ☐ dk/u Other physical problems or symptoms? Describe:_____

_____

☐ yes ☐ no ☐ dk/u Being treated by another health care professional?

For:_____

Date of most recent physical exam?_____

Do you have any other medical conditions that we should know about?

_____