PATIENT FORMS

Dr. D's Smiles

DACZKOWSKI ORTHODONTICS

TODAY'S DATE _____

MEDICAL/DENTAL HISTORY

PATIENT NAME _____ SEX _____ AGE _____

PREFERS TO BE CALLED? _____ BIRTHDATE _____

WERE YOU REFERRED BY A DENTIST? Yes/No _____ IF SO, NAME _____

EMAIL ADDRESS FOR NOTIFICATIONS _____

RESPONSIBLE PARTY (NAME) FOR TREATMENT BILLING _____

BILLING ADDRESS _____ CITY _____ STATE ___ ZIP _____

CELL NUMBER _____ EMAIL _____

IF PATIENT IS A CHILD COMPLETE

FATHER'S NAME _____ SSN _____ DOB _____

FATHER'S WORK PHONE _____ CELL PHONE _____

MOTHER'S NAME _____ SSN _____ DOB _____

MOTHER'S WORK PHONE _____ CELL PHONE _____

ORTHODONTIC INSURANCE

PRIMARY INSURANCE CO _____ ID# _____

INSURED NAME _____ SSN _____INSURED DOB _____

SECONDARY INSURANCE CO _____ ID# _____

INSURED NAME _____ SSN _____INSURED DOB _____

HOW DID YOU HEAR ABOUT US?

INTERNET SEARCH ☐ MOBILE PHONE SEARCH ☐ MAIL OUT POSTCARD ☐ INTERNET AD ☐

MAIL OUT POSTCARD ☐ INTERNET AD ☐ A FRIEND ☐ OTHER _____

REFERRAL BY DENTIST _____HIS NAME SO WE CAN THANK HIM/HER _____

DACZKOWSKI ORTHODONTICS

DENTAL HISTORY

PATIENT'S DENTIST _____ YOUR LAST VISIT _____

HAVE THERE BEE ANY INJURIES TO THE FACE, MOUTH OR TEETH? YES ☐ NO ☐

HAVE YOU HAD OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING HABITS?

☐ THUMB OR FINGER SUCKING ☐ LIP BITING ☐ SNORING

☐ GRINDING TEETH AT NIGHT ☐ MOUTH BREATHING

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ☐ YES ☐ NO

ARE YOU AWARE OF ANY SORES, LUMPS OR IRRITATED AREAS IN THE MOUTH? ☐ YES ☐ NO

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ☐ YES ☐ NO

HIS NAME _____ WHEN _____

HAVE YOU BEEN TREATED FOR ■ BAD BITE ☐ TMJ ☐ PERIODONTAL DISEASE

IF SO, BY WHOM _____ ☐ NO

DO YOU HAVE ANY SPEECH PROBLEMS ☐ YES ☐ NO

ARE YOU FRIGHTENED OF ORTHODONTIC TREATMENT ☐ YES ☐ NO

ARE YOU CONCERED ABOUT THE APPEARANCE OF YOUR TEETH ☐ YES ☐ NO

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE ☐ YES ☐ NO

IF SO, WHAT _____

REASON FOR CONSULTATION? _____

HAS THERE EVER BEEN ANY ORTHODONTIC TREATMENT FOR ANY OTHER MEMBER OF THE FAMILY?

☐ YES ☐ NO WERE YOU SATISFIED WITH THE RESULTS ☐ YES ☐ NO WHO DID IT? _____

MEDICAL HISTORY

IS YOUR GENERAL HEALTH GOOD ☐ YES ☐ NO ARE YOU UNDER THE CARE OF A PHYSICIAN AT THIS TIME?

☐ YES ☐ NO EXPLAIN _____

NAME OF YOUR FAMILY PHYSICIAN? _____ARE YOU TAKING ANY MEDICATIONS?

☐ YES ☐ NO IF SO, NAME THEM _____

IS THE PATIENT ALLERGIC TO ANY MEDICATION ☐ YES ☐ NO DATE OF LAST PHYSICAL _____

HAS THE PATIENT EVER TAKEN ANY DIET MEDICATION ☐ YES ☐ NO NAME _____

HAS THE PATIENT HAD TONSILS AND/OR ADENOIDS REMOVED ☐ YES ☐ NO AGE _____

HAS THE PATIENT EVER HAD SERIOUS ILLNESS OR BEEN HOSPITALIZED? EXPLAIN _____

_____

DOES THE PATIENT HAVE ANY SPECIAL PROBLEMS NOT LISTED _____

HAS THE PATIENT EVER BEEN ADVISED BY THEIR PHYSICIAN TO TAKE AN ANTIBIOTIC PRIOR TO ANY DENTAL TREATMENTS ☐ YES ☐ NO NAME OF THE ANTIOBIOTIC? _____

WHAT IS THE PATIENT'S HEIGHT _____ WEIGHT _____ HAS THE PATIENT SHOWN SIGNS OF INCREASED GROWTH RECENTLY ☐ YES ☐ NO HAS THE PATIENT REACHED PUBERTY ☐ YES ☐ NO

FATHER'S HEIGHT _____ MOTHER'S HEIGHT _____ SIBLINGS HEIGHT _____

DOES THE PATIENT NOW OR HAVE THEY EVER HAD ANY OF THE FOLLOWING

☐ YES ☐ NO TUBERFULOSIS

☐ YES ☐ NO ADD

☐ YES ☐ NO HIGH BLOOD PRESSURE

☐ YES ☐ NO HEART CONDITION

☐ YES ☐ NO LIVER DISEASE

☐ YES ☐ NO HEPATITIS (TYPE? ____)

☐ YES ☐ NO HEART ANGINA

☐ YES ☐ NO DRUG ADDICTION

☐ YES ☐ NO HERPES (ORAL-COLD SORES)

☐ YES ☐ NO MITRAL VALVE PROLAPSE

☐ YES ☐ NO EARACHES

☐ YES ☐ NO INFLAMMATORY RHEUMATISM

☐ YES ☐ NO ARTIFICIAL HEART VALVE

☐ YES ☐ NO ALLERGIES

☐ YES ☐ NO ULCERS

☐ YES ☐ NO HEART MURMUR

☐ YES ☐ NO JAW PAIN

☐ YES ☐ NO ANEMIA

☐ YES ☐ NO LUNG DISEASE

☐ YES ☐ NO ENDOCARDITIS

☐ YES ☐ NO KIDNEY TROUBLE

☐ YES ☐ NO LOW BLOOD PRESSURE

☐ YES ☐ NO HEART PACEMAKER

☐ YES ☐ NO PSYCHIATRIC TREATMENT

☐ YES ☐ NO VENEREAL DISEASE

☐ YES ☐ NO HEART ATTACK (CORONARY)

☐ YES ☐ NO HEADACHES

☐ YES ☐ NO BLOOD DISSORDER/BLEEDING

☐ YES ☐ NO CONGENITAL HEART DISEASE

☐ YES ☐ NO JAW CLICKING

☐ YES ☐ NO ARTHRITIS

☐ YES ☐ NO HEART SUGERY, WHEN_____

☐ YES ☐ NO ALLERGIES TO METAL

☐ YES ☐ NO STROKE

☐ YES ☐ NO RHEUMATIC FEVER

☐ YES ☐ NO TONSILLITIS

☐ YES ☐ NO PROSTHETIC JOINT

☐ YES ☐ NO EMOTIONAL PROBLEMS

☐ YES ☐ NO EPILEPSY

☐ YES ☐ NO GLAUCOMA

☐ YES ☐ NO FAINTING SPELLS

☐ YES ☐ NO ASTHMA

☐ YES ☐ NO XRAY RADIATION CANCER THERAPY

☐ YES ☐ NO AIDS OR HIV POSITIVE

☐ YES ☐ NO DIABETES

☐ YES ☐ NO OTHER _____

☐ I HAVE COMPLETED THE HEALTH QUESTIONNAIRE AND CERTIFY THAT THE PRECEDING INFORMATION IS TRUE AND CORRECT. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED. I GRANT AUTHORITY TO THE DOCTOR AND STAFF TO PERFORM ALL PROCEDURES AND TREATMENTS IN THE PATIENT'S BEST INTERST. I UNDERSTAND THAT, WHERE APPROPRIATE, CREDIT BUREA REPORTS MAY BE OBTAINED.

_____

TYPE NAME AS SIGNATURE OF PARENT/GUARDIAN

Dr. D's Smiles

DACZKOWSKI ORTHODONTICS

_____

TYPE NAME AS SIGNATURE FOR PATIENT