altschul orthodontics

Welcomes You!

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.
Please fill out the requested information below completely. The better we communicate, the better we can care for you.

Today's Date: _____ Sex: ☐ M ☐ F

Name: _____

Email: _____

Where and when are best places and times to reach you? _____

_____

Other family members seen by us: _____

_____

_____

General Dentist: _____

Phone: _____ Date of Last Visit: _____

Your Health History

Do you have a personal physician? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription / over the counter drugs? ☐ Yes ☐ No

Please list each one: _____

FOR WOMEN: Are you taking any birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week No.: _____

Are you nursing? ☐ Yes ☐ No

Are you allergic to any of the following drugs or materials?

☐ Yes ☐ No Aspirin
☐ Yes ☐ No Any Metals / Plastic
☐ Yes ☐ No Codeine
☐ Yes ☐ No Dental Anesthetics
☐ Yes ☐ No Other: _____
☐ Yes ☐ No Erythromycin
☐ Yes ☐ No Latex
☐ Yes ☐ No Penicillin
☐ Yes ☐ No Tetracycline

Have you ever had any of the following diseases or medical problems?

☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No Anemia
☐ Yes ☐ No Artificial Bones / Joints / Valves
☐ Yes ☐ No Asthma
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Allergic to Any Drugs
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer
☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Emphysema / Difficulty Breathing
☐ Yes ☐ No Epilepsy / Seizures / Fainting
☐ Yes ☐ No Fever Blisters / Herpes
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Heart Attack / Stroke
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Surgery / Pacemaker
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No High / Low Blood Pressure
☐ Yes ☐ No HIV+ / AIDS
☐ Yes ☐ No Hospitalization
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Psychiatric Problems
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Rheumatic / Scarlet Fever
☐ Yes ☐ No Severe / Frequent Headaches
☐ Yes ☐ No Shingles
☐ Yes ☐ No Sickle Cell / Traits
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Ulcers / Colitis
☐ Yes ☐ No Venereal Disease

Your Dental History

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

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

Do you like your smile? ☐ Yes ☐ No

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? _____

Do you generally breath through your mouth? ☐ Yes ☐ No
☐ While Awake? ☐ While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you smoke or use smokeless tobacco ? ☐ Yes ☐ No

What is the frequency? _____

Do you take bisphosphonates? ☐ Yes ☐ No

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

_____

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Date_____

Confidential Responsible Party Information

A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address____ Home Phone_____ Work Phone_____ Cell Phone_____

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

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

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

Insurance Information

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

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

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

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

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

I authorize the dental staff to perform the necessary dental services required. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____