



Name: _____ Date: _____

Date of Birth: ____ MM ____ DD ____ YY Age: ____ Sex: ____ Occupation: _____

Home Address: _____ City: _____ Postal: _____

Home Tel: _____ Daytime Tel: _____ Cell Work Home

Patient's Dentist: _____ Physician: _____ Physician's Tel: _____

Who may we thank for referring you? _____

Person responsible for account: _____

Do you have an insurance plan that covers orthodontic treatment? Yes No Unsure

MEDICAL HISTORY - HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

| | | | | | |
|------------------------|--|-------------------------------|--|-----------------|--|
| Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | H.I.V. / A.I.D.S. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A, B, or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |

If you responded YES to any of the above questions, please give pertinent information: _____

Are any drugs or medications now being taken? Yes No Please list and give reasons: _____

Do you have any history of major illness and/or operations? _____

List any allergies or drug sensitivities (including sensitivity to metals): _____

Have your tonsils or adenoids been removed? Yes No At what age? _____

Do you have a tendency to colds? Yes No Sore Throats? Yes No Ear Infections? Yes No

(Women) Are you pregnant? Yes No

Have you ever taken medication for osteoporosis, bone cancer, or bone disease? Yes No Name of medication _____

DENTAL HISTORY

Have you ever been treated for a jaw joint problem, including surgery? Yes No

Have you ever experienced clicking, cracking or locking of the jaw joints? Yes No

Have there been any injuries to the face, mouth or teeth? Yes No Please describe: _____

Have you ever sucked your thumb or finger? Yes No Until what age? _____

Do you have any speech problems? Yes No

Do you have frequent canker or cold sores? Yes No

Are you a mouth breather? Yes No While Asleep: Yes No While Awake: Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Have you ever had a previous orthodontic examination? Yes No

Do you want orthodontic treatment? Yes No

Has any other family member had braces or orthodontic treatment? Yes No

Please name the family member if treated in our office: _____

When did you last see your dentist? _____

Reason for orthodontic consultation: _____

RELEASE OF INFORMATION: I hereby give Dr. Ronald L. Sperber, Dr. David Simone, and/or members of staff permission to release information concerning me or my child's dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress.

Patient Signature

Date

Signature of Team member

Dr. Ronald L. Sperber/Dr. David Simone