Welcome to the **NEW HOPE - SOLEBURY DENTAL ASSOCIATES** Orthodontist

1 ABOUT YOU

Today's Date: _____ Age: _____

Name: _____
LAST FIRST MI SALUTATION

I prefer to be called: _____ ☐ MALE ☐ FEMALE

Birthdate: ____/ ____/ ____ SSN: _____ DL #: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

E-mail Address: _____

Cell #: (_____) _____-_____ Hm #: (_____) _____-_____

Wk #: (_____) _____-_____ Ext: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you?

_____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk #: (_____) _____-_____ Ext: _____ SSN: _____

Birthdate: ____/ ____/ ____

Person Responsible for Account: _____

Cell #: (_____) _____-_____ Hm #: (_____) _____-_____

Billing Address: _____

Relation: _____ SSN: _____

Employer: _____

Wk #: (_____) _____-_____ Ext: _____

3 ORTHODONTIC INSURANCE

Orthodontic Coverage? Y N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____-_____

Group #: _____ Insured's ID #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/ ____/ ____

Insured's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance | Orthodontic Coverage? Y N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____-_____

Group #: _____ Insured's ID #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/ ____/ ____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Cell #:(_____) _____-_____ Hm #: (_____) _____-_____

4 MEDICAL HISTORY

Do you have a personal physician? ☐Yes ☐ No

Physician's Name: _____

Wk #: (_____) _____-_____ Date of last visit? _____

Are you under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

CONTINUED ON BACK

5 MEDICAL HISTORY *continued*

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

Are you taking any prescription/over-the-counter or supplemental drugs? Y N

Please list each one: _____

Do you smoke or use tobacco, in any form? Y N

Have you ever taken Fosamax, or any other bisphosphonate? Y N

Do you snore or hold your breath in your sleep? Y N

For Women: Are you using a prescribed method of birth control? Y N

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

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? (Please circle Y or N)

Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joint /Valves
Y N Arthritis
Y N Severe/Frequent Headaches
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Hemophilia/Abnormal Bleeding
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Diabetes
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Ever Hospitalized
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Treatment
Y N Rheumatic/Scarlet Fever
Y N Asthma
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Latex
Y N Erythromycin
Y N Jewelry/Metals
Y N Dental Anesthetics
Y N Penicillin
Y N Tetracycline
Y N Other

6 DENTAL/ ORTHO HISTORY

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

_____

_____

Has your seen an orthodontist before? Y N Dentist? Y N

Treatment done: _____

Previous orthodontist: _____

Date of last visit? Dentist: _____ Orthodontist: _____

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Y N Still have wisdom teeth Y N Missing or extra permanent teeth

Are you happy with the way your smile looks? Y N

If not, what would you change? _____

_____

7 HABITS/PROBLEMS

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Sensitive Teeth
Y N Difficulty Opening Mouth
Y N Tonsils/Adenoids Removed
Y N Play Musical Instrument
Y N Injury to Head/Mouth
Y N Nursing Bottle
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust
Y N Joint Noises
Y N Bite Uncomfortable
Y N Jaw Stuck/Locked/Out
Y N TMJ/TMD

Explain injury: _____

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 that I may need during diagnosis and treatment with my informed consent._____ _____

Signature Date

Medical History Update

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

Date: _____ Comments: _____ Signature: _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____