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ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please complete both sides of this form.

Patient Name: _____ Age: _____ Birthdate: _____ Sex: _____
Home Address: _____ Nickname: _____
Home Phone: _____
Cell Phone: _____
School: _____ Grade: _____ E-mail: _____

FAMILY

Father's Name: _____ Living? Yes No Occupation: _____
Relationship to patient: biological step-father adoptive
Mother's Name: _____ Living? Yes No Occupation: _____
Relationship to patient: biological step-mother adoptive
Siblings (name and age): _____
Parents' Marital Status: Married Divorced Separated Not married
Patient living with: Mother _____ Father _____ Other _____

PERSON(S) RESPONSIBLE FOR FINANCIAL MATTERS

Name(s): _____
Address: _____
Home phone: _____
Bus. phone: _____
Place of Employment: _____
SS #: _____
Is the patient covered by insurance for orthodontic treatment?
Company? _____

PLEASE SUPPLY INSURANCE FORMS IF YOU WOULD LIKE US TO FILE FOR YOUR REIMBURSEMENT.

	PATIENT'S DENTIST	PATIENT'S PHYSICIAN	REFERRED BY
Name:	_____	_____	_____
Address:	_____	_____	_____
Phone:	_____	_____	_____

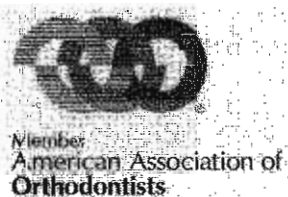
Has any other orthodontist been consulted regarding this patient? _____
Has the patient had previous orthodontic treatment (please explain)? _____

Please describe any major illnesses or hospitalizations: _____

Does the patient have any allergies? _____
Is the patient taking any medication(s)? _____

Has the patient been under the care of a physician during the past 3 years, other than for routine examination (please explain)? _____

ANDREW M. SICKLICK, D.D.S., L.L.C.
123 GROVE AVE., SUITE 107
CEDARHURST, NY 11516
(516) 569-5559



MEDICAL HISTORY

Has the patient ever had (please circle):

- | | | |
|-------------------------|--------------------------|------------------------|
| Abnormal blood pressure | Emotional problems | HIV positive |
| Anemia | Epilepsy and/or seizures | Kidney disease |
| Arthritis | Headaches/migraines | Oral ulcers |
| Asthma | Heart disease | Rheumatic fever |
| Blood disorders | Heart murmur | Speech difficulties |
| Cancer | Heart valve condition | Surgery |
| Cold sores | Head or face injury | Thyroid condition |
| Diabetes | Hepatitis | Tuberculosis |
| Endocrine disorders | Herpes | Other (describe below) |

Comments: _____

Does the patient require premedication prior to dental treatment? _____

Has the patient reached puberty (menstruation, voice change, hair...)? Yes No
How long ago? _____

DENTAL HISTORY

Date of last checkup: _____ Were the patient's teeth cleaned? Yes No

How often does the patient brush his/her teeth? _____

Has the patient ever sucked his/her thumb or fingers? Yes No

Is there a history of trauma to any teeth? Yes No Explain: _____

Is there a history of pain in or around the ear? Yes No

Has there been a "pop" or "lock" of the jaw upon opening or closing? Yes No

Is there a history of grinding or clenching the teeth? Yes No

Is there a tongue thrusting habit or other functional problem? Yes No

Are there frequent sore throats or a history of tonsilitis? Yes No

Is there a history of mouth breathing or snoring? Yes No

What is the patient's or parent's primary concern - why are you here? _____

What is expected from orthodontic treatment? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

I have read and understand the above questions. I will not hold the orthodontist or any member of his 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.

Signature of adult patient or parent/guardian of child _____ Date _____