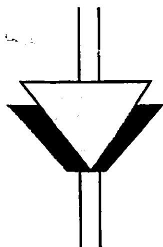

David C. DeGenova, D.D.S.

Specialist in Orthodontics

ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out _both_ sides of this form

Patient's Name: ______________________ Age:______ Birthdate:____________ Sex:_____

Home Address: ______________________ Patient SS #:______________
Street *City, State* *Zip* *Only on Adult Patients*

Home Phone #: (_____) ______________ Best Daytime Phone #: (_____) ______________

INFORMATION FOR PATIENTS WHO ARE MINORS:

Patient's School:______________________ **Grade:**________

Father's Name:______________________ SS #:______________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address:______________________ Home Phone #: (_____) ______________

Employed By:______________________ Position:______________

Work Phone #: (_____) ______________ Cell #: (_____) ______________

Mother's Name:______________________ SS #:______________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address:______________________ Home Phone #:(_____) ______________

Employed By:______________________ Position:______________

Work Phone #: (_____) ______________ Cell #: (_____) ______________

INFORMATION FOR ADULT PATIENTS:

Employed by: ______________________ Position:______________

Work Phone #: (_____) ______________ Cell #: (_____) ______________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse:______________________ SS #:______________

Work Phone #: (_____) ______________ Cell #: (_____) ______________

RESPONSIBLE PARTY OTHER THAN PATIENT OR PATIENT'S GUARDIANS:

Name:______________________ SS #:____________ Relationship to patient:__________

Address:______________________ Home Phone #: (_____)______________

Employed by:______________________ Position:______________

Work Phone #: (_____) ______________ Cell #: (_____)______________

INSURANCE INFORMATION:

Name of Insurance Company:______________________ Insured's Name:______________

Insured's Date of Birth:______________ Relationship to Patient:______________

MEDICAL HISTORY

Has patient had or does have any of the following?

	Yes	No		Yes	No		Yes	No
Rhuematic Fever	☐	☐	Persistent Headaches	☐	☐	Diabetes	☐	☐
Heart Mumor	☐	☐	Neck Pains	☐	☐	Ulcers	☐	☐
High Blood Pressure	☐	☐	Nerve or Brain Disease	☐	☐	Herpes	☐	☐
Heart Attack/ Stroke	☐	☐	Migraine	☐	☐	Psoriasis	☐	☐
Blood Vessel Disease	☐	☐	Epilepsy	☐	☐	Cancer (any Type)	☐	☐
Blood Disorder	☐	☐	Mental Health Problems	☐	☐	Sleep Apnea	☐	☐
AIDS/ HIV Infection	☐	☐	Bone Disorders	☐	☐	Ear Disorder	☐	☐
Hepatitis	☐	☐	Arthritis (Any Type)	☐	☐	Sinus Infection	☐	☐
Swollen Glands Nodes	☐	☐	Allergies	☐	☐	Fever Blisters	☐	☐

Please list any other significant information about the patient's medical history:____________________________

____.

Yes / No

☐ ☐ Is the patient under a physician's care at present? If yes, reason____________________________

☐ ☐ Is the patient presently, or has patient ever been, under the care of a physician or psychologist?

If yes, reason____

☐ ☐ Is patient currently taking any medication (s)? If yes, list____________________________________

☐ ☐ Is the patient allergic to any medication (s)? If yes, list____________________________________

☐ ☐ Has the patient ever had any general anesthesia? If yes, when?______________________________

DENTAL HISTORY

☐ ☐ Have you ever had an injury in the head and neck area? If yes, describe__________________________

☐ ☐ Have you fallen and bumped your chin, or received a blow to your jaws?

If yes, describe____

☐ ☐ Do you clench or grind your teeth? If yes, while ☐ sleeping ☐ under stress ☐ other____________

☐ ☐ Do your jaw muscles ever feel tired? If yes, when____

☐ ☐ Do you ever notice soreness, tightness or pain in the muscles around the jaws and face?

If yes, describe____

☐ ☐ Does it hurt to chew? If yes, where does it hurt ____

☐ ☐ Do you hear clicking (popping) or grating sounds in your jaw joints?

☐ ☐ Was there some specific event that started the joint sounds? If yes, describe______________________

____

☐ ☐ Have you ever experienced difficulty in opening or closing your jaws?

☐ ☐ Have your jaws ever "locked" closed? If yes, describe______________________________________

☐ ☐ Have your jaws ever "locked" wide open? If yes, describe___________________________________

Yes / No

☐ ☐ Do any of your teeth hurt? If yes, ☐ upper right ☐ upper left ☐ lower right ☐ lower left

☐ ☐ Have any wisdom teeth been removed? If yes, how many?____________________

☐ ☐ Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe____________

☐ ☐ Have you ever had any previous orthodontic treatment (braces)? If yes, when?____________

Doctor's name/ phone number____________________

☐ ☐ Have there been any injuries to your mouth or teeth? If yes, describe____________

Habits (past or present)

Yes	No		Yes	No	
☐	☐	Finger/ Thumbsucking	☐	☐	Gum Chewing
☐	☐	Lip Biting	☐	☐	Ice Chewing
☐	☐	Nail Biting	☐	☐	Other____________

Growth and Development

Yes / No

☐ ☐ Has the patient reached adolescent growth?____________________

☐ ☐ Girls - Has monthly cycle started yet? If yes, when?____________________

☐ ☐ Boys - Has voice changed yet? If yes, when?____________________

☐ ☐ Is the patient adopted? Does patient know? ☐ Yes ☐ No ____________

☐ ☐ Are there any learning disabilities? If yes, explain____________________

Patient's present height__________ Mother's height__________ Father's height__________

☐ ☐ Are there other children in the family? If yes, please list names and ages____________

Name of General Dentist:____________________ Who referred you to us?____________

Date of last dental checkup:____________ Was the patient's teeth cleaned? ☐ Yes ☐ No

Please describe any unusual dental experiences____________________

____.

Please describe why you sought this consultation:____________________

____.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patients clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

____________________ ____________________

(Signature of Responsible Adult) (Date)