Welcome to the Orthodontist

Our purpose is to provide the highest quality orthodontic care with a skilled staff, educated in current technologies. We strive to provide clear communication, exceed expectations and give patients and families a positive orthodontic experience.

Patient Information

Patient Name: _____ Date: _____/_____/_____
Last First Middle

School: _____ Sex: ❑ Male ❑ Female Age: _____ Birthdate: _____/_____/_____

Describe Patient's Temperament: _____Hobbies/Interests: _____

If Patient is a Minor, Give Parent's or Guardian's Name with Whom the Patient Lives _____

Whom May We Thank for Referring You to our Office? _____

Patient/Parent Primary Concern: _____

Person Responsible for Account

(In the Case of a Minor, the Responsible Party is the Parent or Guardian with Whom the Patient Lives)

Name: _____ Marital Status: _____
Last First Middle

Address: _____
Street City State Zip

Email Address: _____@_____ Permission to Receive Texts Y N Emails Y N

Years at Address: ____ Home #: _____Work #: _____Cell #: _____

Soc. Sec. No. _____ Birthdate: ____/____/____ Relationship to Patient: _____

Employer: _____ Occupation: _____# Yrs Employed: _____

Spouse's Name: _____ Relationship to Patient: _____
Last First Middle

Employer: _____ Occupation: _____# Yrs Employed _____

Soc. Sec. No. _____ Birthdate: ____/____/____ Work Phone: _____

Dental Insurance Information

Dental Coverage: ❑Yes ❑No Orthodontic Coverage: ❑Yes ❑No

Primary Insured's Name: _____ Insured's Soc. Sec. No. _____

Dental Insurance Company: _____ Group #: _____

Dental Insurance Company Address: _____ Phone #: _____

Secondary Insured's Name: _____ Insured's Soc. Sec. No. _____

Dental Insurance Company Address: _____ Phone #: _____

I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO MY OR MY CHILD'S INSURANCE CLAIM. I HEREBY AUTHORIZE PAYMENT TO VALERIE D. MARTONE, DMD, MSD OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Signed: _____ Date: _____

Emergency Information

Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____ Work #: _____

PLEASE CONTINUE ON REVERSE

Patient Dental History

Dentist's Name: _____ Last Dental Exam: _____

Dentist's Address: _____ Phone #: _____

Who first noticed the need for an orthodontic examination? ❑ Dentist ❑ Parent ❑ Patient

	YES	NO	EXPLAIN
Has anyone in the family ever had orthodontic treatment?			
If so, has the result been stable and satisfactory?			
Has the patient had any teeth removed?			
Is the patient concerned about the appearance of the teeth?			
Has the patient ever been teased about the appearance of the teeth?			
Is the patient worried about receiving orthodontic treatment?			
Has the patient had previous orthodontic treatment or consultation?			
Does the patient have difficulty chewing and swallowing food?			
Does the patient have any speech problems?			
Does the patient grit, grind or clench the teeth?			
Has the patient ever sucked a thumb or finger? If so, until what age?			
Does the patient bite lips, tongue, fingernails, pencils, other?			
Does the patient breathe through the mouth?			
Do the gums bleed easily?			
Has the patient ever received a severe blow to the teeth or jaws?			
Have there been any other injuries to the face, mouth or teeth?			
Does the patient have frequent earaches or soreness around the ears?			
Does the patient have clicking or popping of the joint in front of the ear?			
Has the jaw ever locked open or closed? Open ___ Closed ___			
If so, when did it first occur? How often?			
Do you consider the patient to be under more stress than most people?			
Does the patient have difficulty in opening the mouth wide?			
Does the patient play a musical instrument? If so, which one?			

CHILDREN ONLY: Has the patient reached puberty? ____ Height: _____ Weight: _____ Is patient an adopted child? _____

GIRLS: Has she started menstruation? ____ When? _____ BOYS: Has his voice changed? _____ When: _____

Please list names and birthdates of other children in the family. Include height and weight of older natural siblings:

NAME	BIRTHDAY	HEIGHT/WEIGHT

Patient Medical History

Physician's Name: _____ Phone #: _____

	YES	NO	EXPLAIN
Is the patient in good health?			
Is the patient currently under the care of a physician?			
Does the patient have a tendency to colds, sore throats, ear infections?			
Have tonsils and adenoids been removed? What age?			
Any drugs or medications now being taken: If so, please list			
Have you ever taken the category of medications called bisphosphonates or been treated for osteoporosis, bone cancer or Paget's disease?			

Has the patient any history or difficulty with any of the following:

____ Allergies
____ Arthritis
____ Anemia
____ Asthma
____ Bleeding Disorder
____ Bone Disease
____ Chronic Cough
____ Chronic Sinus Problems
____ Cold Sores or Mouth Ulcers
____ Convulsions
____ Diabetes
____ Endocrine Disturbance
____ Epilepsy
____ Fainting
____ Growth Disturbance
____ Hearing Problems
____ Heart Conditions/Murmur
____ Hepatitis
____ HIV (A.I.D.S.)
____ Kidney
____ Latex or Nickel Allergy
____ Learning Disability
____ Mental Problems
____ Pain of the Face
____ Persistent Cough or TB
____ Rheumatic Fever
____ Serious Illness
____ Sexually Transmitted Disease
____ Thyroid
____ Vision

Are there any other conditions the orthodontist should know about? _____

Are you a tobacco user? ❑ Yes ❑ No

Signature (Parent's Signature if a Minor) _____

UPDATES (Date & Initial) _____ _____ _____ _____ _____ _____ _____ _____