



Upper Bucks Orthodontics  
Robert A. Azarik, DMD, MDS  
*Experienced, comprehensive care for beautiful smiles*

## Personal History

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
Sex M F (circle)  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Person financially responsible for account \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Patient's Dentist \_\_\_\_\_ Address \_\_\_\_\_  
Patient's Physician \_\_\_\_\_ Address \_\_\_\_\_  
Patient's School \_\_\_\_\_ Grade \_\_\_\_\_  
Patient's Height \_\_\_\_\_ Weight \_\_\_\_\_  
Father's Height \_\_\_\_\_ Mother's Height \_\_\_\_\_  
List any musical instruments played \_\_\_\_\_  
List any hobbies and/or sports \_\_\_\_\_  
Do you have: Dental Insurance Y N Name of Carrier \_\_\_\_\_  
Orthodontic Insurance Y N Address \_\_\_\_\_  
I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber \_\_\_\_\_ Employer \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

## Confidential Medical and Dental History

### Medical

(circle)

|  |   |   |
|--|---|---|
| Does the patient have any health problems? .....                   | Y | N |
| If so, explain _____   |   |   |
| Has the patient been ill recently? .....                           | Y | N |
| Has the patient been under the care of a physician recently? ..... | Y | N |
| If so, for what reason? _____                                      |   |   |
| Is the patient taking any medications? .....                       | Y | N |
| If so, please list them _____                                      |   |   |
| Does the patient have any allergies? .....                         | Y | N |
| If so, please list them _____                                      |   |   |
| Does the patient have any emotional problems? .....                | Y | N |
| Is the patient physically handicapped? .....                       | Y | N |
| Are there any heart problems? .....                                | Y | N |
| If so, is antibiotic premedication needed? .....                   | Y | N |

### Medical (cont.)

|   |   |   |
|---|---|---|
| Does the patient have or ever had any of the following diseases or problems? .....              | Y | N |
| Seizures or convulsions .....   | Y | N |
| Congenital heart lesions .....  | Y | N |
| Diabetes .....  | Y | N |
| Rheumatic heart disease, rheumatic fever, scarlet fever .....                                   | Y | N |
| Cardiovascular disease .....  | Y | N |
| Sinus trouble .....   | Y | N |
| Hepatitis, jaundice, liver disease .....  | Y | N |
| STD (syphilis, etc.) .....  | Y | N |
| AIDS (HIV+) .....   | Y | N |
| Any blood disorders .....   | Y | N |
| Epilepsy .....  | Y | N |
| Heart murmur .....  | Y | N |
| Mumps .....   | Y | N |
| Measles, German Measles .....   | Y | N |
| Chicken Pox .....   | Y | N |
| Malignancies .....  | Y | N |
| Breathing or lung problems .....  | Y | N |
| Frequent tonsillitis or sore throats .....  | Y | N |
| Are the tonsils and adenoids present? .....   | Y | N |
| Has the patient ever been premedicated with an antibiotic before dental work of any kind? ..... | Y | N |
| Has the patient (female) started with menstrual periods? .....                                  | Y | N |
| If so, date of onset _____  |   |   |
| Has the patient ever been cautioned by a physician to any aspect of health? .....               | Y | N |
| If so, what was it? _____   |   |   |

## Dental

|  |   |   |
|--|---|---|
| What are the main concerns you would like Orthodontics to accomplish? _____  |   |   |
| Has the patient ever been evaluated or had orthodontic treatment before? .....                                     | Y | N |
| If so, When, Where and What was done? _____  |   |   |
| Are there any problems with speech? .....  | Y | N |
| If so, explain _____   |   |   |
| Does the patient exhibit any of the following:   |   |   |
| Snoring .....  | Y | N |
| Mouth breathing .....  | Y | N |
| Grinding or clenching teeth .....  | Y | N |
| Thumb or finger habit .....  | Y | N |
| Lip biting .....   | Y | N |
| Nail biting .....  | Y | N |
| Biting of pencils or other objects .....   | Y | N |
| Is tooth brushing done on a regular basis (at least 2 times per day)? .....  | Y | N |
| Flossing? .....  | Y | N |
| Has there ever been instruction on the care of teeth and gums? .....   | Y | N |
| Has the patient seen a dentist in the last 12 months? .....  | Y | N |
| Were there any problems (cavities, gum disease, toothaches, etc.) that haven't been taken care of? .....           | Y | N |
| Are there any dental problems of parents, brothers, or sisters? (missing or extra teeth, poor bite, crowding) .... | Y | N |
| Are there any clicking or popping noises of the lower jaw joint (near the ear) when opening or closing? .....      | Y | N |
| Is there any pain associated with this area? .....   | Y | N |
| Are there any difficulties biting into or chewing foods? .....   | Y | N |
| Have there been any injuries to the face, mouth, teeth, or chin? .....   | Y | N |