Upper Bucks Orthodontics

Robert A. Azarik, DMD, MDS

Experienced, comprehensive care for beautiful smiles

Personal History

Date______________

Patient's Name_____________________________ 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)

Question		
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? (circle)

Condition		
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? ________________________________

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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