Perelmuter & Goldberg ORTHODONTICS

Welcome

So that we may provide the best care to you please fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Today's Date _____

Name_____ Sex_____ Marital Status_____

Address_____

City_____State_____Zip_____

Birth date_____ E Mail_____ Social Security#_____

Home Phone_____ Cell Phone_____ Work Number_____

Employer_____ Occupation_____

General Dentist_____ Date of last dental cleaning/check-up_____

Physician _____ Phone Number _____ Date of last Physical _____

Who may we thank for recommending our office to you? _____

Spouse/Additional Contact Information

Name_____Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

E Mail_____ Home phone_____

Cell Phone_____ Work Phone_____

Employer_____ Occupation_____

Insurance Information

Policy Holder's Name_____

Policy Holder's Social Security Number _____ Policy Holder's ID Number_____

Policy Holder's Birth date _____ Relationship to Patient _____

Employer_____ Employer's Address_____

Insurance Company_____ Group # _____

Insurance Company Address _____Insurance Phone Number _____

Secondary Insurance

Policy Holder's Name_____

Policy Holder's Social Security Number _____ Policy Holder's ID Number_____

Policy Holder's Birth date _____ Relationship to Patient _____

Employer_____ Employer's Address_____

Insurance Company_____ Group # _____

Insurance Company Address _____Insurance Phone Number _____

Medical/Dental Health History

Are you under the care of a physician? Yes No

If yes, explain _____

List all drugs you are currently taking:_____

List any medical condition: _____

Are you allergic to any medications, metals, plastics, or latex? (Please list) _____

Other Allergies/Sensitivites: _____

Have you ever been told that they needed to be pre-medicated for dental appointment? Yes No

Are you pregnant? Yes No

If so, how many weeks? _____

Have you had any extractions of permanent teeth? Yes No

If yes: How long ago _____ Reason for extraction _____

Have you ever had any of the following habits? (Please Circle all that apply)

Clenching/grinding teeth	Lip sucking/ biting	Mouth breather
Nail biting	Tongue thrusting	Prolonged bottle/pacifier
Thumb/finger sucking	Tobacco use	

Have you ever been evaluated or had orthodontic treatment before?	Yes	No
Have you ever been treated by a Periodontist?	Yes	No
Have your tonsils or adenoids been removed?	Yes	No
Have you experienced jaw joint pain/ discomfort (TMJ/TMD)?	Yes	No
Have you ever worn a mouth guard or splint?	Yes	No
Have you ever had an injury to: Teeth, Mouth, Chin	Yes	No
Have you been treated for mental illness, emotional disorders, or depression	Yes	No
Are there any behavioral problems, ADD, ADHD, learning disabilities or intellectual disadvantages?	Yes	No
Do you suffer from headaches?	Yes	No
Do you suffer from sleep apnea?	Yes	No
Sores, lumps, blisters or irriated areas in mouth or lips	Yes	No
Food catching or collecting between teeth	Yes	No
Sore or bleeding gums	Yes	No
Loose permanent teeth	Yes	No
Speech problems	Yes	No
Clicking, popping or grating noise in your jaw when chewing	Yes	No
Tender or sensitive teeth	Yes	No
Limitations in opening or moving your lower jaw or chewing	Yes	No
Is there currently any uncompleted dental work that has been recommended?	Yes	No

If yes, explain: _____

What are the main concerns that you would like orthodontics to accomplish? _____

_____

What aspect of orthodontic treatment are you most concerned with? If more than one applies, please number 1-4 in order of importance, 1 being most important.

Quality_____ Cost _____ Discomfort _____ Time_____

Please make any additions or explain conditions as appropriate: _____

_____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status. I hearby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____

Signature _____

Date _____