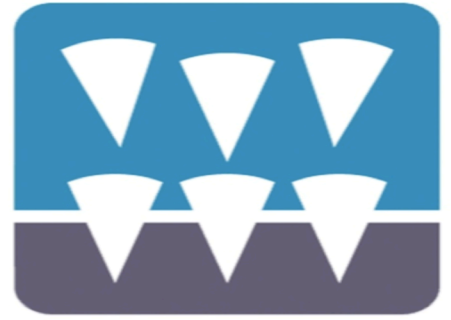


# Perelmuter & Goldberg ORTHODONTICS



## 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 \_\_\_\_\_



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 irritated 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: \_\_\_\_\_

\_\_\_\_\_

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### 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 hereby 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 \_\_\_\_\_