Perelmuter & Goldberg ORTHODONTICS

Welcome

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

Patient Information

Today's Date _____

Name_____ Sex_____

Address_____

City_____State_____Zip_____

Birth date _____ E Mail_____

Home Phone_____ Child's Cell Phone (if appropriate) _____

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? _____

Parent or legal Guardian

Name_____ Relationship to Patient _____ Marital Status _____

*Address_____

City_____ State_____ Zip_____

E Mail_____ Birth date _____ Social Security Number _____

Home phone_____ Cell Phone_____ Work Phone_____

Employer_____ Occupation_____

*Please enter same as above (SAA) when applicable

Parent or legal Guardian

Name_____ Relationship to Patient _____ Marital status _____

Address_____

City_____ State_____ Zip_____

E Mail_____ Birth date _____ Social Security Number _____

Home phone_____ Cell Phone_____ Work Phone_____

Employer_____ Occupation_____

General Information

School _____

Hobbies/ Activites _____

Sibling's Name and Ages _____

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 Number _____

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 Number _____

Insurance Company Address_____ Insurance Phone number _____

Medical/Dental Health History

Is the patient under the care of a physician? Yes No

If yes, explain_____

List all drugs the patient is currently taking:_____

List any medical conditions: _____

Is the patient allergic to any medication, metal, plastics, or latex? (Please list) _____

Other Allergies/ Sensitivites: _____

Has the patient ever been told that they needed to be pre-medicated for dental appointment? Yes No

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?

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

Has the patient ever been evaluated or had orthodontic treatment before? Yes No

Has the patient ever been treated by a Periodontist? Yes No

Has the patient had tonsils or adenoids removed? Yes No

Has the patient experienced jaw joint pain / discomfort (TMJ / TMD)? Yes No

Has the patient ever worn a mouth guard or splint? Yes No

Has the patient ever had an injury to: Teeth, Mouth, Chin Yes No

Has the patient 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

Does the patient suffer from headaches? Yes No

Does the patient 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 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 hear by 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 _____