Member American Association of Orthodontists

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New Patient Information

Thank you for choosing Dr. Levin's office, where we are committed to providing you with personalized service and care beyond your expectations. At your first visit you will receive a comprehensive, *complimentary* evaluation of your orthodontic concerns.

This questionnaire is crucial to the information gathering process, and your answers may impact Dr. Levin's diagnosis and treatment recommendations. Please complete this questionnaire and bring it with you to your appointment. We look forward to meeting you!

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ MI ____ Preferred Name _____

Mailing address (Street and Unit) _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ DOB (mm/dd/yy) _____ Age _____

Work Phone _____ OK to contact at work? ☐ Y ☐ N Email _____

Gender ☐ Male ☐ Female

Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

How did you hear about us? Who may we thank for referring you to our office? Please specify _____

Preferred method to receive appointment confirmations? ☐ Text ☐ Email ☐ Both Text & Email

PARENT OR BEST PERSON TO CONTACT IN CASE OF EMERGENCY

First and Last Name (with Title) _____ Relation to patient _____

Best Contact Phone _____ Alternate Contact Phone _____

☐ Home ☐ Cell ☐ Work ☐ Home ☐ Cell ☐ Work

WHO WILL BE SIGNING TREATMENT AND FINANCIAL CONSENT FORMS FOR THIS PATIENT?

This person should be present at the initial evaluation and will be signing this form as well as any future financial forms

First and Last Name (with Title) _____ Relation to patient _____

Driver's License # _____ State issued _____ DOB (mm/dd/yy) _____

Street Address, City, State, Zip *(if different than patient's)* _____

< 3 yrs at this address? ☐ Y ☐ N Best Contact Phone _____ Email address _____

Occupation _____ Current Employer _____ Yrs with Current Employer _____

If we will be submitting insurance forms on your behalf, or you would like insurance forms filled out for you so that you can file claims with your Insurance company, please fill out this section:

INSURANCE INFORMATION

Primary policy holder's full name _____ Relation to patient _____ DOB (mm/dd/yy) _____

Dental Insurance Carrier Name _____ Employer _____

Group # _____ ID # / SSN _____ Orthodontic benefit? ☐ Y ☐ N ☐ Unsure

Insurance Carrier Address, City, State, Zip _____

Insurance Phone _____ Insurance Fax _____

Secondary policy holder's full name _____ Relation to patient _____ DOB (mm/dd/yy) _____

Dental Insurance Carrier Name _____ Employer _____

Group # _____ ID # / SSN _____ Orthodontic benefit? ☐ Y ☐ N ☐ Unsure

Insurance Carrier Address, City, State, Zip _____

Insurance Phone _____ Insurance Fax _____

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MEDICAL-DENTAL HISTORY QUESTIONNAIRE FOR ADULTS

Your answers are for office records only, and are completely *confidential*. A thorough medial history is essential to a complete orthodontic evaluation. Please mark yes, no, or don't know/understand (dk/u), when asked.

MEDICAL HISTORY

☐yes ☐no ☐dk/u Are you in good general health? Date of last medical check-up or visit to a physician: _____

Reason for this visit: _____

☐yes ☐no ☐dk/u Has there been any change to general health in the past year?

☐yes ☐no ☐dk/u Is there currently treatment ongoing for any chronic medical condition or has treatment been provided for any medical condition within the past year? Please provide reason: _____

☐yes ☐no ☐dk/u Is there a history of serious illness, hospitalization, or operations within the past five years?

Please specify: _____

☐yes ☐no ☐dk/u Is there currently a need for medications (includes birth control) or non-prescription drugs/supplements of any kind?

Attach additional paper, if necessary.

Medication: _____ Dose: _____ Taken for: _____

Medication: _____ Dose: _____ Taken for: _____

Medication: _____ Dose: _____ Taken for: _____

☐yes ☐no ☐dk/u Have you ever taken any medication to strengthen your bones (e.g., Fosamax, Actonel, Boniva)?

If *yes*, for how long (# Yrs)? _____ ☐ oral ☐ I.V.

☐yes ☐no ☐dk/u Do you currently chew or smoke tobacco? If *yes*, amount daily: _____ # Yrs: _____

☐yes ☐no ☐dk/u Is there a history of any allergies *OR* any peculiar/adverse reactions to any medications or injections? Check all that apply:

☐ Local anesthesia "dental freezing" (e.g., novocaine, lidocaine, xylocaine)? ☐ Codeine or other narcotic ☐ Aspirin

☐ Ibuprofen (Motrin, Advil) ☐ Penicillin ☐ Other antibiotic (including sulfa drugs) - Which? _____

☐ Latex (gloves, balloons) ☐ Metals (jewelry, clothing snaps) ☐ Plastics

☐ Seasonal or environmental (includes food)? Please specify: _____

Other allergies? _____

If yes, type of reaction experienced: _____

Allergy Alert: ☐ Y / ☐ N

Now or in the past, have you had:

☐yes ☐no ☐dk/u Arthritis or joint problems? *

☐yes ☐no ☐dk/u Diagnosis of osteoporosis/osteopenia?

☐yes ☐no ☐dk/u Orthopedic total joint replacement?

☐yes ☐no ☐dk/u Any injury to the face, head, neck?

☐yes ☐no ☐dk/u Diabetes or low blood sugar? *

☐yes ☐no ☐dk/u Thyroid or other endorcrine problem?

☐yes ☐no ☐dk/u Stomach ulcer, hyperacidity, acid reflux?

☐yes ☐no ☐dk/u Hepatitis (type?), jaundice or other liver problem?

☐yes ☐no ☐dk/u Kidney problem?

☐yes ☐no ☐dk/u Cancer, tumor, radiation therapy or chemotherapy?

☐yes ☐no ☐dk/u AIDS or HIV positive?

☐yes ☐no ☐dk/u Vision, hearing, or speech problem?

☐yes ☐no ☐dk/u Seizures, fainting spells, neurologic problem?

☐yes ☐no ☐dk/u Frequent headaches, neck aches, or migraines?

☐yes ☐no ☐dk/u Mental health struggle, to include anxiety or depression?

☐yes ☐no ☐dk/u Drug or alcohol dependency?

☐yes ☐no ☐dk/u Chest pain, shortness of breath, tire easily, swollen ankles?

☐yes ☐no ☐dk/u Heart defect, heart murmur, rheumatic heart disease, heart valve replacement?

☐yes ☐no ☐dk/u Angina, arteriosclerosis, stroke or heart attack?

☐yes ☐no ☐dk/u Excessive bleeding, bruising, or anemia? *

☐yes ☐no ☐dk/u High or low blood pressure?

☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?

☐yes ☐no ☐dk/u Bronchitis or emphysema?

☐yes ☐no ☐dk/u Asthma, sinus problems, hay fever?

☐yes ☐no ☐dk/u Frequent ear infections, colds, throat infections?

☐yes ☐no ☐dk/u Tonsils and/or adenoids removed?

☐yes ☐no ☐dk/u Breathing through mouth or snoring at night?

☐yes ☐no ☐dk/u Excessive fatigue or trouble staying focused?

☐yes ☐no ☐dk/u A diagnosis of sleep apnea?

☐yes ☐no ☐dk/u For women only – are you pregnant? If *yes*, what is the expected delivery date? _____

☐yes ☐no ☐dk/u For women only – Are you currently trying to get pregnant?

☐yes ☐no ☐dk/u For women only – Are you post-menopausal or post-hysterectomy?

☐yes ☐no ☐dk/u History of any other medical or emotional problems not listed?

Please describe: _____

Medical Alert: ☐ Y / ☐ N

Pre-med Alert: ☐ Y / ☐ N

Patient's First Name: _____

DENTAL HISTORY

☐yes ☐no ☐dk/u Is there a Family Dentist? Name: _____

Address and/or Tel no: _____

Date of last visit: _____ X-rays taken? ☐ Yes ☐ No ☐ Unsure

Reason for this visit: _____

☐yes ☐no ☐dk/u Are visits to the Dentist fairly regular (i.e., every 4 to 6 months)?

☐yes ☐no ☐dk/u Do you brush and floss your teeth routinely?

Brush teeth: ____ x /day Floss teeth: ____ x /day or ____ x /week

Now or in the past, have you had:

☐yes ☐no ☐dk/u Permanent (adult) or "extra" teeth removed?

☐yes ☐no ☐dk/u Chipped or otherwise injured teeth?

☐yes ☐no ☐dk/u Any wisdom tooth problems?

☐yes ☐no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐yes ☐no ☐dk/u Any loose, broken or missing fillings (now)?

☐yes ☐no ☐dk/u Any sores, lumps, or irritations (now)?

☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?

☐yes ☐no ☐dk/u Periodontal "gum" problems or treatment?

☐yes ☐no ☐dk/u Frequent canker sores or cold sores (circle which)?

☐yes ☐no ☐dk/u Problems with saliva quality (feels thick or ropey) quantity (too much or too little)?

☐yes ☐no ☐dk/u Any fluoride supplementation?

☐yes ☐no ☐dk/u Premedication with antibiotics regularly before certain dental procedures?

☐yes ☐no ☐dk/u Tooth grinding or jaw clenching?

☐yes ☐no ☐dk/u Any pain, clicking or locking in jaw?

☐yes ☐no ☐dk/u Difficulty in chewing, jaw opening, or ringing in ears?

☐yes ☐no ☐dk/u Pain or soreness in the muscles of the face or around the ears?

☐yes ☐no ☐dk/u Treatment for "TMD" or "TMJ" problems?

☐yes ☐no ☐dk/u Treatment by any other dental specialist?

Name: _____

Date: _____

Reason: _____

☐yes ☐no ☐dk/u Anything else regarding your past dental history not listed?

Please describe: _____

TMJ Alert: ☐ Y / ☐ N

ORTHODONTIC AND GROWTH HISTORY

☐yes ☐no ☐dk/u Are the orthodontic problems obvious to you?

☐yes ☐no ☐dk/u Are you sensitive or self-conscious about the appearance of your teeth or face?

☐yes ☐no ☐dk/u Have you had any previous orthodontic treatment?

☐yes ☐no ☐dk/u Is there history of or ongoing frequent oral habit? Check all that apply:

☐ Thumb/finger sucking ☐ Lip biting ☐ Nail biting ☐ Tongue thrusting ☐ Speech ☐ Other

Comments: _____

Habit Alert: ☐ Y / ☐ N

☐yes ☐no ☐dk/u Do you play a musical instrument? _____

☐yes ☐no ☐dk/u Do you participate in any contact sports? _____

Any additional hobbies or interests you would like to share with us: _____

Any specific concerns you have about your teeth? _____

What concerns your family dentist about your teeth? _____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in completing this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of prospective patient: _____ Date Signed: _____

Signature of TC who reviewed this form: _____ Date Signed: _____

Signature of the Doctor who reviewed this form: _____ Date Signed: _____

INSURANCE AUTHORIZATION

(Needs to be signed if you would like us to submit your insurance claims on your behalf. If you would like to send your own claims to your insurance company, please leave this blank.)

To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signature of prospective patient: _____ Date Signed: _____

Patient's First Name: _____