mmo

marina milstein orthodontics

Tell Us About Yourself

Date: _____

Last Name: _____First Name_____ Birthdate: _____ Age: _____
I prefer to be called: _____ Gender: _____ Social Security #:_____
Home Address:_____
Home #:_____ Cell #: _____ Work #:_____ E-Mail: _____
Marital Status: Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Remarried ( ) Single ( )
Employer: _____ Occupation: _____ Length of Employment: _____

Where and when are the best times to reach you _____
Whom may we thank for referring you? _____
Other family members seen by us: _____
Whom may we notify in case of emergency? Name: _____ Phone #: _____

Primary Insurance

Insurance Name: _____ Subscriber Name: _____ Group #: _____
Social Security #: _____ Birthdate: _____ Relation to Patient: _____
Address (If different from patient): _____
Home #: _____ Cell #: _____ E-Mail: _____
Employer: _____ Occupation: _____ Insurance phone: _____

Secondary Insurance Y ( ) N ( )

Insurance Name: _____ Subscriber Name: _____ Group #: _____
Social Security #: _____ Birthdate: _____ Relation to Patient: _____
Address (If different from patient): _____
Home #: _____ Cell #: _____ E-Mail: _____
Employer: _____ Occupation: _____ Insurance phone: _____

Dental History

Why are you interested in orthodontic treatment? _____
Are you currently in pain? Yes ( ) No ( )
Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? Yes ( ) No ( )
Have you ever experienced a mouth or chin injury? Yes ( ) No ( )
How often do you brush your teeth? _____ Floss your teeth? _____

Present Dentist:

Date of last Dental cleaning: _____Check-up: _____X-rays: _____
Have you ever been evaluated for orthodontic treatment?_____
Are you seeking a second opinion? _____

PLEASE COMPLETE REVERSE SIDE

Do you have any of the following?

Tongue Thrust	Y N	Mouth Breathing	Y N	Thumb/Finger Sucking	Y N
Chewing on Objects	Y N	Nail Biting	Y N	Periodontal (gums) problems	Y N
Tongue/Cheek Biting	Y N	Clenching/Grinding Teeth	Y N	Mobility in your teeth	Y N
Lip Sucking/Biting	Y N	Speech Problems	Y N	Sensitivity to cold and/or hot	Y N

Medical History

Physician's name: _____ Phone #: _____ Date of last visit: _____
Address: _____
Are you currently under the care of a physician? Yes ( ) No ( ) Please explain: _____
Please describe your current physical health: Good ( ) Fair ( ) Poor ( ) Do you smoke? Yes ( ) No ( )
Please list all drugs that you are currently taking: _____
_____
_____
Please list all drugs and/or other things that can cause you allergic reactions: _____
_____
Women: Are you pregnant? Y ( ) N ( ) Are you taking Birth Control Pills? Y ( ) N ( )

Latex Allergy Y N Metal Allergy Y

Do you or have you ever experienced the following?

Abnormal Bleeding	Y N	Fainting Spells	Y N	Mitral Valve Prolapse	Y N
Alcohol Abuse	Y N	Fever Blisters	Y N	Pacemaker	Y N
Anemia	Y N	Glaucoma	Y N	Persistent Cough	Y N
Arthritis	Y N	Hay Fever	Y N	Psychiatric Problems	Y N
Artificial Bones/Joints	Y N	Headaches	Y N	Radiation Treatment	Y N
Artificial Valves	Y N	Heart Attack	Y N	Rheumatic Fever	Y N
Asthma	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Blood Transfusion	Y N	Heart Surgery	Y N	Seizures	Y N
Cancer	Y N	Hemophilia	Y N	Shingles	Y N
Chemotherapy	Y N	Hepatitis	Y N	Sickle Cell Disease	Y N
Chicken Pox	Y N	Herpes	Y N	Sinus Problems	Y N
Colitis	Y N	High Blood Pressure	Y N	Steroid Therapy	Y N
Congenital Heart Defect	Y N	HIV+/AIDS	Y N	Stroke	Y N
Diabetes	Y N	Hospitalized for Any Reason	Y N	Thyroid Problems	Y N
Difficulty Breathing	Y N	Kidney Problems	Y N	Tonsillitis	Y N
Drug Abuse	Y N	Liver Disease	Y N	Tuberculosis (TB)	Y N
Emphysema	Y N	Low Blood Pressure	Y N	Ulcers	Y N
Epilepsy	Y N	Lupus	Y N	Venereal Disease	Y N

Please list any other serious medical condition(s) that you have experienced: _____
_____

Authorizations

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the orthodontist.
I authorize my insurance company to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient: _____Date_____

Signature of Doctor: _____ Date _____