

Date:				
Patient's Name				
Address				
Home PhoneI	Birth Date	Social Security #		
Whom may we thank for referring you to our o	office?			
	esponsible Party Infor			
E-mail				
		ırital Status		
		Cell #		
		Relationship to Patient		
Employer	Occupation	No. Years Employed		
Spouse's Name	Relatio	nship to Patient		
Employer	Occupation	No. Years Employed		
Social Security #	Birth Date	Work #		
С	ental Insurance Inforn	nation		
Insured's Name	Insur	Insured's Social Security #		
Insurance Company	Group No	Local No		
Insurance Co. Address		Phone No		
Do you have dual coverage? $\ \square$ Yes $\ \square$	No If Yes:			
Insured's Name	Insur	Insured's Social Security #		
Insurance Company	Group No	Local No		
Insurance Co. Address		Phone No		
	Emergency Informat	ion		
Name of nearest relative not living with you _				
Complete Address				
Phone				
I understand that where appropriate, credit but	ureau reports may be obtained	d.		
Signature (Parent's signature if minor)				
Updates (date & initial)				

MEDICAL HISTORY

Are you allergic to any medications, latex or metals? No Do you have a history of a major illness? No Have you had any major operations? Have you had any major operations? Have you ever been involved in a serious accident? Circle any of the medical conditions below that you have had or currently have. Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Prolonged Bleeding Anthritis Epilepsy High Blood Pressure Radiation/Chemotherapy Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever Bone Disorders Heart Problems Kidney Problems Tuberculosis Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer Are there any medical conditions we have not discussed that you feel we should be aware of? DENTAL HISTORY Dentist What concerns you most about your teeth? Yes No Are you presently in any dental pain? Yes No Have you ever lost or chipped any teeth? Yes No Have you ever lost or chipped any teeth? Yes No Have there been any injuries to face, mouth or teeth? Yes No Do your gums bleed when you brush? Yes No Do your gums bleed when you brush? Yes No Do your any type of thumb or tongue habit? Are you a mouth breatther? Yes No Have you ever seen an orthodonticit? If yes, who and when? How did they feel about the result? What is your attitude toward receiving orthodontic treatment? How did they feel about the result? What is your attitude toward receiving orthodontic treatment? How Grey No Are you aware of your jaw clicking or popping?	Physician				Date of Last Visit				
Yes No Are you taking any medications? Yes No Are you allergic to any medications, latex or metals? Yes No Do you have a history of a major illness? Yes No Have you had any major operations? Yes No Have you ever been involved in a serious accident? Yes No Have you ever been involved in a serious accident? Circle any of the medical conditions below that you have had or currently have. Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia Anemia Dizziness Herpes Prolonged Bleeding Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever Bone Disorders Heart Murmur Nervous Disorders Tuberculosis Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer Are there any medical conditions we have not discussed that you feel we should be aware of? **DENTAL HISTORY** Dentist** What concerns you most about your teeth? Yes No Are you presently in any dental pain? Have you ever experienced any unfavorable reaction to dentistry? Yes No Have you ever experienced any unfavorable reaction to dentistry? Yes No Have you ever post or chipped any teeth? Yes No Have you ever post or chipped any teeth? Yes No Have there been any injuries to face, mouth or teeth? Yes No Do you gums bleed when you brush? Yes No Do you have any type of thumbor to nogue habit? Yes No Have you ever seen an orthodonitis? If yes, who and when? Have you ever seen an orthodonitis? If yes, who and when? Have you ever seen an orthodonitis? If yes, who and when? Yes No Have you ever seen an orthodonitis? If yes, who and when? Yes No Have you ever been told that you grind your teeth you have in your award of clenching your teeth during the day? Yes No Have you ever experienced chronic ringing in your ears? Yes No Have you ever experienced chronic ringing in your ears? Yes No Have you ever experienced chronic ringing in your ears? Yes No Have you ever experienced chronic ringing in your ears? Yes No Have you ever experienced chronic ringing in your ea									
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Yes No	Yes	No	Are you taking any	medications?					
Yes No	Yes	No	Are you allergic to	any medications, latex or meta	als?				
No Have you had any major operations? No Have you ever been involved in a serious accident? Circle any of the medical conditions below that you have had or currently have. Ahonormal bleeding/Hemophilia Diabetes	Yes	No							
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Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Mark S. Farina, D.M.D. to perform a complete orthodontic evaluation.

Signature:	Date:	