FARINA ORTHODONTICS
Live. Love. Smile.

Date: _____

Patient's Name _____

Address _____

Home Phone _____ Birth Date _____ Social Security # _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

E-mail _____

Name _____ Marital Status _____

Residence _____

Mailing Address _____

How long at this address? _____ Home # _____ Work # _____ Cell # _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birth Date _____ Work # _____

Dental Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? ❑ Yes ❑ No If Yes: _____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No *(If yes, please fill in details)*

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? _____

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 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 experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
Please list some hobbies or interests: _____
Female patients only: _____
Yes No Are you pregnant? _____

BENEFITS

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**: _____