Passamano Orthodontics

Date _____

PATIENT INFORMATION / HEALTH HISTORY

(Adult Patient)

Patient's name _____ Birthdate _____ Age _____

Nickname_____ Sex □ M □ F Marital Status □ Single □ Married

Who can we thank for referring you? _____

Address _____City_____Zip Code_____

Primary Phone # _____ Secondary Phone # _____

□ Home □ Cell □ Work □ Home □ Cell □ Work

E-Mail Address _____

Occupation _____ Employer's Name & Location _____

Orthodontic Insurance □ Yes □ No □ Unknown Name of Dental Insurance _____

Social Security # or Member ID # (for verification of coverage) _____

Spouse's name _____ Phone _____ □ Home □ Cell □ Work

Spouse's Employer and Location _____

Orthodontic Insurance □ Yes □ No □ Unknown Name of Dental Insurance _____

Spouse's Social Security # or Member ID # (for verification of coverage) _____

Patient's Dentist _____ Patient's Physician _____

What is Your Primary Concern about Patient's (Your) Teeth? _____

How soon would you like to start treatment?_____

Are you interested in having your teeth straightened? _____

Other orthodontic consultation and/or treatment _____

When _____ Where _____

Please compete the other side

MEDICAL HISTORY - Please Check if You Had or Have the Following:

___ Allergies
- ___ Penicillin
- ___ Local anesthetic
- ___ Medication or drugs
- ___ Nickel
- ___ Others

___ Anemia
___ Asthma
___ Blood disease
___ Abnormal blood pressure
___ Colds Frequent?
___ Sinus trouble
___ Diabetes
___ Epilepsy
___ Convulsions
___ Dental implant
___ Prolonged recent illness
___ Heart disease/defect
___ Are you pregnant?
___ Hepatitis
___ Headaches Often?
___ Tonsils removed Age ___
___ Adenoids removed Age ___
___ Liver or kidney disease
___ Rheumatic fever
___ Scarlet fever
___ Sore throats Frequent?
___ Earaches/infections Frequent?
___ Have you ever fainted?
___ Positive for HIV antibodies
___ Other medical condition?

_____

DENTAL HISTORY - Please Fill in the Blank Where Applicable:

Thumb sucking until age _____ Which Thumb? _____

Finger sucking until age _____ Which Finger(s)? _____

Nail / Lip Biting _____ **Teeth Grinding/Clenching** _____

Snoring / Sleep Apnea _____ Mouth breathing _____

Sleep with lips parted _____ Extractions/ Surgery_____

Speech therapy _____ Other? _____

Injuries to Face, Jaw, Head, Teeth? _____

_____

Please Evaluate the Following as Good, Fair, or Poor:

Chewing _____ Sleep _____ # Hours _____

_____
Signature

In the event that any information on this form is changed, it is the responsibility of the patient to notify us immediately.