1 WELCOME TO OUR ORTHODONTIC PRACTICE

Thank you for selecting our office for an evaluation of your orthodontic condition. We work in a traditional family-oriented dental setting and strive to provide you with the best care possible. Our commitment is to excellence in every aspect of your care and experience with us. I hope your visit will be informative and helpful. To help us with this evaluation, please fill out these pages. And if you have questions, please ask us – we will be happy to help.

2 PERSONAL INFORMATION

TODAY'S DATE ____

How should we address correspondence to you? ❒ Mrs. ❒ Ms. ❒ Dr. ❒ Mr. ❒ Other ________________________

Name ______________________________________ Sex _____ Age______ Date of birth _________________________

Address ____

City, Zip ____

How may we contact you:

- ❒ Email (for in-office use ONLY) ____
- ❒ Home phone number ____ Messages ok? Y N
- ❒ Cell phone number ____ Messages ok? Y N
- ❒ Work phone number ____ Messages ok? Y N

Person to contact in case of an emergency ____

Relationship ____ Contact phone __________________________________

Whom may we thank for mentioning our office? ____

Did you visit our website before this appointment? Y N Was that important to your decision? Y N

Other family members treated by Dr. Masuda? ____

Have you had previous orthodontic consultation or treatment? ____

What is the main reason you seek this consultation? ____

____

Please write down any questions you don't want to forget to ask during your examination. I know this happens, so use this space ____

____

____

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3 EMPLOYMENT & INSURANCE INFORMATION

Employer ____

Employer address ____

Social Security #____

Phone# ____ Occupation ____

Insurance Carrier ________________________________ Ins. Phone# ____

Insurance Address____

Group #_______________________________________ Member ID# _______________________________________

Additional Coverage:

Subscriber Name________________________________ Date of Birth ____

Relationship____

Employer _____________________________________ Social Security # ____________________________________

Insurance Carrier ________________________________ Ins. Phone # _______________________________________

Insurance Address ____

Group # ______________________________________ Member ID# _______________________________________

4 MEDICAL HISTORY

While orthodontic treatments are obviously primarily confined to the mouth, your overall health status and medications you may be taking do have an effect on oral tissues and the biology of tooth movement. Therefore, we ask that you complete this part of the form and describe or explain any questions you answer yes. We will review this with you at your examination.

Name of your physician ______________________ Date of last visit ______________________

Y N Are you presently under any medical care? Please explain: ______________________

Y N Are you presently taking any medication, including non-prescription medicines, antacids, vitamins, or aspirin? __ Please list: ______________________

Y N Are you presently taking bisphosphonate (like Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa or Bonefos)? ______________________

Y N Have you ever had an allergic/adverse reaction to any medications or latex? ______________________

Y N Are you allergic to anything else (including "hay fever")?______________________

Y N Have you had your tonsils or adenoids removed? At what age? ______________________

Y N Have you had any serious accident involving head injuries? (If yes, please describe)______________________

____

If you have had or have been treated for any of the following, please describe:

Y N Heart trouble, heart murmur, heart defect, congenital heart disease, rheumatic fever, scarlet fever, or irregular heart beats? ______________________

Y N Heart attack, heart surgery, cardiac pacemaker or valve, hardening of the arteries, angina, shortness of breath or chest pain upon exertion? ______________________

Y N Abnormal blood pressure, thyroid problems, anemia or excessive bleeding? ______________________

Y N Immune system problems or disorders? ______________________

Y N Asthma, tuberculosis, emphysema, chronic cough or other respiratory problems? ______________________

Y N Hepatitis, jaundice or liver disease? ______________________

Y N Cancer, leukemia, tumors, radiation therapy, or chemotherapy? ______________________

Y N Glaucoma, diabetes, kidney disease or renal dialysis? ______________________

Y N Stomach or intestinal disease or ulcers? ______________________

Y N Stroke, seizures, convulsions, fainting, epilepsy or any neurological disorders? ______________________

Y N Arthritis, rheumatism, joint replacement or implant? ______________________

Y N Blood transfusion, anemia, hemophilia, or sickle cell diseases? ______________________

Y N Swollen lymph glands, parathyroid or thyroid problems, excessive thirst, frequent urination?___________

Y N Is there any other relevant medical history that we have not covered on this form? ______________________

____

Y N Are there any other issues you would prefer to discuss in private? ______________________

5 DENTAL HISTORY

Name of your dentist ____

Date of last visit ____

Approximately how often do you visit your dentist? Every _______ months

Date of last dental x-rays ____

Y N Do you clench or grind your teeth at night?

Y N Do you take antibiotics before dental procedures?

Y N Do you breathe mainly through your mouth?

Y N Have you ever had any teeth removed?

Y N Are you naturally missing any permanent teeth?

Y N Do you have your third molars ("wisdom teeth")?

Y N Have you injured or chipped any teeth?

Y N Are you concerned about an underdeveloped or overdeveloped jaw?

Y N Have you ever had an injury to the head, neck, or jaw?

Y N Have you ever had a click, catch, pop or noise in either jaw joint? ❒ R ❒ L ❒ Both

Y N Have you ever had pain in or around your ears, temples, or jaw joint? ❒ R ❒ L ❒ Both

Y N Have you ever had pain or difficulty when chewing, talking, or using your jaws?

Y N Has your jaw ever been "stuck," "locked," or "out"?

Y N Do you have frequent headaches?

Y N Do your gums bleed when you brush?

Y N Have you ever had periodontal (gum) treatments?

Y N Have you ever had your teeth ground or your bite adjusted?

Y N Have you ever worn a bite plate, other mouth appliance, or braces?

Y N Is there any other dental related history that might affect orthodontic treatment?

The information that I have given is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I acknowledge receipt of the Notice of Privacy Practices.

Please sign ____

Reviewed by ____ Date ____