Welcome to Falls Orthodontics!

ADULT FORM

Mr./Mrs./Miss./Ms. /Dr. Name____
(Please circle) First Middle Last
Age _______ Birthdate______________________ SS#_____________________ Home Phone #_________________________

Spouse Name:__________________ Patient Cell Phone #____________________E-mail address_________________________
Text message reminder of appointments? □ Yes/No □ Email reminder of appointments?□Yes/No □

Home Address ____
Street City State Zip

Employer________________________________Phone________________________City/State______________________________

Will you be the responsible party for the account? Yes □ / □ No If NO, Please complete the following:

Are you a Student?□Yes/ No□ Dental Insurance coverage? □ Yes/No □ Provide insurance card & ID#____________________
Who will be responsible for your account? _________________________Relationship____________________________
Billing Address:___________________________City______________________________State___________Zip______________
______ I give Falls Orthodontics permission to speak to _____________________________________for account purposes.
(initial) (person who is responsible for the account)

Please let us know who referred you to us-so we can thank them! Name:____

Medical History - Please THICK ONE YES or NO

YES□ NO □ Birth defects or hereditary problems?
YES□ NO □ Bone fractures, any major accidents?
YES□ NO □ Rheumatoid or arthritic conditions?
YES□ NO □ Endocrine or Thyroid problems
YES□ NO □ Kidney problems?
YES□ NO □ Diabetes?
YES□ NO □ Cancer or been treated for a tumor?
YES□ NO □ Stomach ulcer or hyperacidity?
YES□ NO □ Polio, mononucleosis, tuberculosis, pneumonia?
YES□ NO□ Problems of the immune system?
YES□ NO□ Hepatitis, jaundice or liver problem?
YES□ NO □ AIDS or HIV Positive?
YES □ NO □ Skin disorder?
YES □ NO □ Fainting spells, seizures, epilepsy or Neurologic disease?
YES □ NO □ Frequent headaches?
YES □ NO □ History of speech issues?
YES□ NO □ Hay fever, asthma, environmental allergies, sinus trouble, hives?
YES□ NO□ Drug Allergy: ______________or drug reactions?
Describe:______________________________
YES□ NO□ Are you or have you in the past taken medication to prevent osteoporosis?
YES□ NO□ Do you currently have or had a substance abuse problem?
YES□ NO□ Other physical problems or symptoms? _________________
YES□ NO□ Hospitalized/Operation (s)______________________________
____
YES□ NO□ Joint Replacement?___________________________________
YES□ NO □ Are you in good health? Date of most recent physical exam?________________________
YES□ NO□ Being treated by another health care professional?
For:________________________________

YES□ NO□ Mental health or behavioral problems?
YES□ NO□ Vision, hearing, tasting or speech difficulties?
YES□ NO□ Loss of weight recently, poor appetite?
YES□ NO□ Excessive bleeding, black & blue tendency, anemia or bleeding disorder?
YES□ NO□ High or low blood pressure?
YES□ NO□ Easily tired?
YES□ NO□ Chest pain, shortness of breath or swelling ankles?
YES□ NO□ Do you have MRSA?
YES□ NO□ Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, Arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
Year:____________ Specialist_____________________________
YES□ NO□ Sexually transmitted disease?
YES□ NO□ Do you have normal & good diet?
YES□ NO□ Do you have sleep apnea or have been told you snore?
YES□ NO□ Eye, ear, nose, throat condition?
YES□ NO□ Tonsil or adenoid conditions?
YES□ NO□ Are you taking prescription medication? Dosages/mg
Please List:____
____
YES□ NO□ Are you taking any NON prescription? Please list:
____
YES NO Have you ever taken a prescription of bis-phosphonate?
____
Any other condition or concern: __________________________
YES□ NO□Premedication for any Dental Work?
***********FEMALE PATIENT************
YES□ NO□Are you pregnant?
YES□ NO□Are you taking birth control pills?
YES□ NO□Are you anticipating becoming pregnant? (X-Rays)

Dental History

General Dentist Name:______________________________________ Address: ___________________________
Last cleaning date____________ Panoramic x ray taken?_______ Current with restorative?_______ Decay present?____________

YES☐NO☐Past injured permanent teeth? Area________ replaced w/filling?______ crown?_________ removed?________________
YES☐NO☐Aware of loose fillings? Area:_________ broken________ missing ________ scheduled repair appointment___________
YES☐NO☐Have you had any serious trouble associated with any previous dental treatment? explain:__________________________
____date_____________________
YES☐NO☐"Gum Boils" frequent canker sores/cold sores? Prescription taken:_________________ toothpaste used:_____________
YES☐ NO☐Mouth breathing habit -
YES☐ NO☐ Snoring -
YES☐ NO☐ Difficulty in breathing? -
YES☐ NO☐ Wear CPAP or BiPAP?
YES☐NO☐History of extra teeth? - Have been removed? ☐YES ☐NO
YES☐ NO☐ Congenitally missing teeth? - Have been replaced?☐YES ☐NO ☐Bridge or Implant☐
YES☐ NO☐Wisdom Teeth/Third Molars Removed? Year Date or age____________
YES☐NO☐Other Permanent teeth been removed? Area______________________ Year Date or age_______________

Periodontal

YES☐ NO☐ Have you ever had periodontal (gum) treatment?
Periodontist or Dentist_________________________ date last treatment______________________
YES☐ NO☐ Bleeding gums? .... YES☐ NO☐Bad taste? ………YES☐NO☐ Mouth infections? …….. YES☐NO☐ currently taking RX?

Endodontic

YES☐ NO☐ Teeth/Tooth sensitive to hot? ……. YES☐ NO☐ Sensitive to cold? ....YES☐NO☐ Do teeth throb/ ache?
YES☐NO☐"Dead Teeth"/ root canal treatment? Area: __________________date____________Dentist___________________

Orthodontic

YES☐ NO☐ Have you ever had orthodontic treatment? Appliance(s):_____________________________Orthodontist:_____________
How long was treatment: ________ how long wore a retainer__________still wear?_______ age started______________
YES☐NO☐ Any teeth/bite **irritating** cheek? YES☐ NO☐ Bite Lip? YES☐NO☐ Bite Tongue? YES☐ NO☐ Bite Palate?
YES☐NO☐ Jaw fractures/surgery: upper or lower____________date:_____________, cysts?,_________date____________________
YES☐NO☐Food impaction between teeth? Area: _____________Dentist aware?______recommended treatment?_________________
YES☐NO☐Concerned about spacing? Area: ___________, crooked/crowding? Area:____________, protruding teeth?______________
YES☐ NO☐ Concerned about Upper Jaw development?,……. YES☐NO☐ Lower Jaw development?_________________
YES☐ NO☐ Past thumb/finger sucking habit? Until age: ________ …….YES☐ NO☐self stop? …… YES☐NO☐Dentist intervene?
YES☐ NO☐ Abnormal swallowing habit (tongue thrusting)? YES☐ NO☐appliance placed? age____________
YES☐ NO☐ Tooth grinding? ….. YES NO Jaw clenching? ……YES☐ NO☐Clicking? ……YES ☐NO☐ Locking? ….YES ☐NO☐Pain?
YES☐ NO☐ Wear splint/ guard? Date/year received splint__________currently use?_______Date/year first symptoms started_______
YES☐ NO☐ Ringing in the ears? First noticed. Year date- or age______________________
YES☐ NO☐ Have you ever been treated for "TMD"/TMJ issues? Care Giver____

Date:___________________Treatment:____
YES☐NO ☐ Currently are you experiencing jaw pain? 0 = no pain, 10= severe pain: Today=______Past=_______ Right or Left
Frequency of TMD pain: daily_____, 1-2 X weekly______,1-2 X monthly ______other:___________________________
YES☐NO☐ Is there a pattern related to pain occurrence? Upon waking ________ Morning______ Afternoon_____ Evening_______
After Eating______how long are you in pain?__________________ taking RX________________________
YES☐ NO☐Difficulty chewing? Date started:______________, Right Joint_________Left Joint_________Both__________________
YES☐ NO☐Is there any history of an accident or injury? Please explain ____date_________
YES☐ NO☐Has any family member had jaw surgery?____

Main concern for todays visit:____

I give permission, release and authorize:

Falls Orthodontics doctors and qualified staff to take diagnostic records for the purpose of planning of orthodontic & or other related treatment. * The use of orthodontic records for professional consultations, research, education or publication in professional journals. * Any information from the insurance company relating to orthodontic or related treatment. *To submit insurance claims pertinent to treatment & to collect payment from the group insurance benefits otherwise payable to me. *To share this patient's treatment information with collaborating dentists and surgeon when appropriate. *This office will not be held responsible for any problems arising out of inadequate information not disclosed.

Signature of patient:____Date:__________________

Signature of reviewing doctor: ____ Date:_______________