CENTRAL MASSACHUSETTS ORTHODONTIC ASSOCIATES, PC

Adult Patient Information Please Print

Patient Name _____ Nickname _____ Date _____

Female/Male Birthdate _____/_____/_____ Age _____ Email _____

Address _____

_____ Height _____ Weight _____

_____ Home Phone (_____)_____

Zip Code

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

Please list your chief complaint/concern:_____

_____

Responsible Party Information

Patient Information

Spouse Name _____

Date of Birth _____

Occupation_____ Occupation _____

Employed By_____ Employed By _____

Email_____ Email _____

Cell Phone (_____)_____ Cell Phone (_____)_____

Where/Whom to call in case of Emergency_____

Dental Insurance Information

Primary Insured's Name_____ Secondary Insured's Name_____

Social Security Number _____ Social Security Number _____

DOB of Insured _____ DOB of Insured _____

Insurance Company_____ Insurance Company_____

Ins. Co. Phone (_____)_____ Ins. Co. Phone (_____)_____

Policy Number_____ Policy Number_____

Group Number _____ Group Number _____

Medical Information

Your Physician_____ Phone (_____)_____

Are you in good health? Yes____ No____

History of major illness or conditions_____

I require antibiotic premedication for dental appointments. Yes____ No_____

Yes		No	DK/U*
	Allergies		
	Asthma, sinus problems, hay fever		
	Anemia, excessive bleeding or bruising		
	Any injuries to face, head or neck		
	Arthritis or joint problems		
	Birth defects or hereditary problems		
	Bone disorders, fractures or major injuries		
	Cancer, tumor, radiation or chemotherapy		
	Cardiovascular disease, heart defects		
	Chest pain, shortness of breath		
	Diabetes or low blood sugar		
	Emotional problems		
	Endocrine or thyroid problems		
	Epilepsy or convulsion		
	Fever blisters/herpes		
	Frequent ear or throat infections, colds		

Yes		No	DK/U*
	Frequent headaches or migraines		
	High or low blood pressure		
	History of osteoporosis		
	HIV - AIDS		
	Hypoglycemia		
	Immune system disorders		
	Kidney problems		
	Mental health disturbance or depression		
	Rheumatic fever		
	Seizures, fainting, neurologic problems		
	Polio, mononucleosis, TB, pneumonia		
	Sexually transmitted infections		
	Skin disorder (other than common acne)		
	Ulcers/GERD/Reflux		
	You tire easily upon exertion		

***Don't know/understand**

Please list all present medications _____

_____

_____

Have tonsils or adenoids been removed? Yes____ No____

Have you been diagnosed with sleep apnea? Yes____ No____

Do you use CPAP? Yes____ No____

Do you use tobacco products? Yes ____ No ____

Please list any implanted medical device _____

Females Do you take bisphosphonates? Yes____ No____

Are you pregnant? Yes____ No____

Please describe any other medical conditions that you have, not listed above.

_____

_____

Dental Information

Name of General Dentist _____

Yes		No	DK/U*
	Have you had a recent dental exam?		
	Do you have regular cleanings?		
	Injuries to mouth or teeth?		
	Previous orthodontic treatment?		
	Adult teeth removed for braces?		
	Have non-restorable teeth been extracted?		
	Have wisdom teeth been extracted?		
	Have you had any root canals?		
	Do you have any bridges?		
	Do you have any dental implants?		
	Any sensitive or sore teeth?		
	Bleeding gums, bad taste or mouth odor?		
	Jaw fractures, cysts or infections?		
	Has jaw ever locked open or closed?		
	Have you had treatment specific for TMJ?		
	Clicking in jaw joints?		
	Soreness in jaw or facial muscles?		

Yes		No	DK/U*
	Difficulty eating or chewing?		
	Food impaction between the teeth?		
	Abnormal swallowing (tongue thrust)?		
	Teeth grinding or clenching?		
	Do you wear a nightguard?		
	Difficulty breathing through nose?		
	Are you a mouth breather?		
	History of speech problems?		
	Have you had any jaw surgery?		
	Any teeth irritating lips, cheeks or gums?		
	Frequent mouth sores or herpes sores?		
	I chew on my nails, pens or other object.		
	Any broken or missing fillings?		
	High intake of sweets or sodas?		
	Any diagnosis of gum disease?		
	Any traumatic past dental experience?		

***Don't know/understand**

List sports played_____

Hobbies/Interests_____

Your attitude toward orthodontics ____Eager ____Complacent ____ Not enthusiastic

We welcome your comments and suggestions. _____

_____

_____

Updates (Date & Init - for office use)_____

Signature_____ Date_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status including changes in medications and health history as well as demographic information.

Preferred Name _____ **Acct#** _____

Age at Initial Exam _____**years**_____**months** **DOB** _____

Teeth Present

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Classification of Malocclusion _____

Overjet _____ **mm** **Overbite** _____ **mm** **Openbite** _____

Crowding _____ **Spacing** _____

Constriction Y N _____

_____

↓

Teeth With Wear

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Teeth in Crossbite

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Midlines On Off **MX shifted** _____ **MD shifted** _____

Opening Path _____

Curve-of-Spee **Flat / Mild / Moderate / Two-Plane**

Frenum _____

Mucogingival & Recession Findings

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Oral Cancer Screening _____

TMJ Palpation Right _____ **Left** _____

TMJ Auscult. Right _____ **Left** _____

Examining Dr. _____ **Date**_____