

# Welcome to Cedar Run Orthodontics!

Please take a few moments to fill out this necessary information that will enable us to better serve you. Our staff will be happy to assist you with any questions you may have.

## PATIENT'S INFORMATION

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M/F \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient lives with: \_\_\_\_\_ Home Number: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Work Number: \_\_\_\_\_

E-mail: \_\_\_\_\_ Interests/Hobbies: \_\_\_\_\_

## MEDICAL HISTORY

Physician: \_\_\_\_\_ Last visit: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you under a physician's care presently? Y/N What condition? \_\_\_\_\_

Date Updated: | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ |

### IS THERE ANY FAMILY HISTORY OF: (PLEASE CIRCLE)

Y/N	Heart Disease	Y/N	Kidney Disease	Y/N	Nasal Blockage	Y/N	Emotional Problems
Y/N	Rheumatic Fever	Y/N	Diabetes	Y/N	Drug/Alcohol Use	Y/N	Psychiatric Therapy
Y/N	Heart Murmur	Y/N	Seizures	Y/N	Hepatitis/Jaundice	Y/N	Digestive Disorder
Y/N	High Blood Pressure	Y/N	Asthma	Y/N	Tuberculosis	Y/N	Hospitalization/Surg.
Y/N	AIDS/HIV+	Y/N	Arthritis	Y/N	Thyroid Disease	Y/N	Blood/Bleeding Disorder
Y/N	Frequent Colds	Y/N	Birth Defect	Y/N	Major Illness	Y/N	Unusual Childhood Disease

If you answered YES to any of the above, please explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you taking any medications? Y/N What? \_\_\_\_\_

Do you have any food/drug allergies? Y/N What? (i.e. penicillin, sulfa, latex, food, metals) \_\_\_\_\_

\_\_\_\_\_

Are you taking any medication for osteoporosis? Y/N \_\_\_\_\_

**WOMEN:** Are you pregnant? Y/N \_\_\_\_\_

## GENERAL INFO

Does the patient play a musical instrument? Y/N Which? \_\_\_\_\_  
Does any relative have a similar bite? Y/N Who? \_\_\_\_\_  
Other relatives being treated here: \_\_\_\_\_

## ORAL HEALTH HISTORY

Dentist: \_\_\_\_\_ Last visit: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Why are you seeking treatment? \_\_\_\_\_ Referred by: \_\_\_\_\_

Do you consider treatment in this case to be mainly for: Health    Cosmetics    Psychological    Other

What would you like treatment to accomplish? \_\_\_\_\_

Would you like improvement in facial appearance? Y/N How? \_\_\_\_\_

### IS THERE ANY HISTORY OF: (PLEASE CIRCLE)

Y/N	Clicking of jaw/joints (TMJ)	Y/N	Tongue Thrusting/habit	Y/N	Prior Orthodontic Treatment
Y/N	Pain in Jaw Joints (ears)	Y/N	Grinding teeth (Day/Night)	Y/N	Extra teeth
Y/N	Injuries to the teeth	Y/N	Pen, lip or nail biting	Y/N	Extraction of teeth
Y/N	Injuries to the face	Y/N	Thumb /finger sucking	Y/N	Missing teeth
Y/N	Difficulty Chewing	Y/N	Chewing gum	Y/N	Speech problem
Y/N	Fever blisters/Ulcers	Y/N	Mouth breathing	Y/N	Dry mouth

If you answered YES to any of above, please explain WHAT happened and WHEN? \_\_\_\_\_

Please list any other information which you feel may be of value to the treatment. \_\_\_\_\_

## FINANCIAL

Insurance Subscriber: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Orthodontic Coverage: Y/N \_\_\_\_\_ What Percentage? \_\_\_\_\_ % Max. Benefit? \$ \_\_\_\_\_

Patient Portion? \$ \_\_\_\_\_

To the best of my knowledge, all the preceding answers are true and correct. I hereby give permission to Dr. Greg DeFelice and his clinical team to take necessary x-rays, photos or study models to enable complete diagnosis as well as use of these records for educational purposes.

Patient Signature \_\_\_\_\_ Today's Date \_\_\_\_\_