

PATIENT INFORMATION

ALL ABOUT YOU

Name: _____
 Last First MI Mr Mrs Ms Dr

I prefer to be called: _____

Male: ___ Female: ___ Birthdate: ___ / ___ / ___ Age: ___
 Single Married Divorced Widowed Separated

SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: () _____ Email: _____

Occupation: _____

Employer: _____ How Long?: _____

Work #: () _____ Ext: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Where/when is the best time to reach you?: _____

Whom may we thank for referring you?: _____

Emergency Contact: _____

Phone: () _____

OTHER CONTACT INFORMATION

His/Her Name: _____

Relation: _____

Employer: _____

Phone #: () _____ Ext: _____

DENTAL HISTORY

General Dentist: _____

Date of Last Exam: _____

What are the main concerns that you would like orthodontics to accomplish?: _____

Have you ever had or been evaluated for orthodontic treatment? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

You current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had an injury to your: mouth / teeth / chin?

Do you have any missing or extra permanent teeth? Yes No

Do you generally breathe through your mouth? Yes No
 If yes: While awake? While asleep?

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? Yes No

MEDICAL HISTORY

Your current medical condition is: Good Fair Poor

Are you currently under the care of a physician?
 Yes No Please explain: _____

Physician's Name: _____

Are you taking an prescription/over-the-counter drugs?
 Yes No

Please list each one: _____

Have you ever had any of the following diseases or medical problems?

- Y N Abnormal Bleeding
- Y N Anemia/Radiation Treatment
- Y N Artificial Bones/ Joints/ Valves
- Y N Asthma
- Y N Arthritis
- Y N Blood Transfusion
- Y N Cancer/ Chemotherapy
- Y N Diabetes
- Y N Congenital Heart Defects
- Y N Tuberculosis
- Y N Difficulty Breathing
- Y N Glaucoma
- Y N Drug or Alcohol Abuse
- Y N Emphysema
- Y N Epilepsy/ Seizures/ Fainting
- Y N Fever Blisters/ Herpes
- Y N Heart Murmur
- Y N Heart Surgery/ Pacemaker
- Y N Hemophilia
- Y N Hepatitis
- Y N High/ Low Blood Pressure
- Y N HIV+/ AIDS
- Y N Hospitalization
- Y N Kidney Problems
- Y N Mitral Valve Prolapse
- Y N Psychiatric Problems
- Y N Rheumatic/ Scarlet Fever
- Y N Shingles
- Y N Sinus Problems
- Y N Severe/ Frequent Headaches
- Y N Heart Attack
- Y N Ulcers/ Colitis
- Y N Venereal Diseases

Are you Pregnant? Yes No

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- Y N Aspirin
- Y N Erythromycin
- Y N Penicillin
- Y N Codeine
- Y N Latex
- Y N Tetracycline
- Y N Dental Anesthetics
- Y N Metals/Plastics
- Y N Other

Please list any other drugs/materials that you are allergic to: _____

I understand that the information I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

Signature _____

Date _____

Reviewed _____

Alvetro Orthodontics Lisa Alvetro DDS, MSD, Inc.



were all about smiles