KARSON KUPIEC ORTHODONTICS

PLEASE FILL OUT COMPLETELY

Patient Information

Patient Name _____ Birthdate _____/_____/_____
Last First Middle

Home Addr_____ Sex M F
Street and Mail Address City State Zip

Home Phone _____Cell Ph_____Email_____

How were you referred to our office _____Reason for Visit? _____

Name of your General Dentist _____ Last Dental Exam _____

Responsible Party Information (or person that carries the insurance) PLEASE FILL OUT COMPLETELY

Name_____Patient Relation _____
Last First Middle Initial

Residence_____DOB_____
Street City State Zip

Mail Addr_____Soc. Sec #_____
PO Box City State Zip

Home Phone_____ Cell Phone_____ Work Phone _____Email_____

Policy Holder Name_____ Insurance Company_____

Insurance Address_____ Insurance Phone_____

Policy Holder Employer_____ Soc. Sec #_____

Do you have dual coverage? Y N If yes:

Policy Holder Name _____Insurance Company_____

Insurance Address _____Insurance Phone_____

Policy Holder Employer_____ Soc. Sec#_____

Emergency Contact Information (<u>not living at same address</u>) PLEASE FILL OUT COMPLETELY

Name_____Patient Relation_____
Last First Middle Initial

Home Addr_____
Street City State Zip

Home Phone_____ Cell Phone _____

Email _____

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? ..... YES NO

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? ..... YES NO

HAS PATIENT EVER BEEN UNDER CARE OF PHYSICIAN FOR ILLNESS? ..... YES NO

NATURE OF CARE_____

DOES PATENT HAVE OR HAS PATIENT EVER HAD?

ANEMIA ..... YES NO
ARTHRITIS ..... YES NO
ASTHMA ..... YES NO
BLEEDING DISORDER ..... YES NO
BONE DISORDER ..... YES NO
BREATHING PROBLEM ..... YES NO
DIABETES ..... YES NO
ENDOCRINE PROBLEM ..... YES NO
EPILEPSY ..... YES NO
FAINTING ..... YES NO
HEART CONDITION ..... YES NO
HEPATITIS ..... YES NO
HIGH BLOOD PRESSURE ..... YES NO
KIDNEY PROBLEM ..... YES NO
LIVER INVOLVEMENT ..... YES NO
NERVOUS DISORDER ..... YES NO
PNEUMONIA ..... YES NO
TUBERCULOSIS ..... YES NO
SPEECH PROBLEM ..... YES NO
SWALLOWING PROBLEM ..... YES NO

DOES PATIENT HAVE TENDENCY TO:

COLDS?..... YES NO SORE THROATS?..... YES NO EAR INFECTIONS?..... YES NO

HAVE THE TONSILS AND/OR ADENOIDS BEEN REMOVED? ..... YES NO WHAT AGE?_____

HAS PATIENT REACHD PUBERTY? ..... YES NO

IS THERE A POSSIBILITY PATIENT COULD BE PREGNANT? ..... YES NO

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN AND REASONS_____

_____

LIST ANY ALLERGY OR DRUG SENSITIVITY_____

_____

DENTAL HISTORY

REASON FOR ORTHODONTIC EXAMINATION_____

LIST ANY INJURIES TO THE FACE, MOUTH, OR TEETH_____

DOES PATIENT HAVE OR HAS PATIENT EVER HAD?

THUMB/FINGER SUCKING HABIT ..... YES NO
NAIL BITING HABIT ..... YES NO
TONGUE THRUST HABIT ..... YES NO
MOUTH BREATHING HABIT ..... YES NO
HABIT OF LEANING ON FIST ..... YES NO
TEETH ABSCESS OR GUM BOILS ..... YES NO
PREVIOUS ORTHODONTIC TREATMENT .... YES NO
PREVIOUS ORTHODONTIC CONSULT..... YES NO
MISSING PERMANENT TEETH..... YES NO
EXTRA PERMANENT TEETH..... YES NO
JAW JOINT OR MUSCLE PAIN..... YES NO
POPPING OR CLICKING JAW ..... YES NO
POPPING OR CLICKING JAW ..... YES NO
TEETH CLENCHING/GRINDING ..... YES NO
FREQUENT HEADACHES OR NECKACHES. YES NO
FAMILY MEMBER WITH BRACES ..... YES NO