Piekarsky
ORTHODONTICS
for children & adults

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Date:_____

Patient's Full Name: _____ Prefers to called: _____
Patient's Address: _____

_____
Home Phone: _____ Cell Phone: _____
Patient's Email Address: _____
Patient's Birthday: _____ Age: _____ □ Male □ Female
Favorite Hobbies: _____ School: _____
Names/ages of siblings: _____
Other family members seen by us: _____
Patient's Dentist: _____ Date of Last Visit: _____
Whom may we thank for referring you? _____

Responsible Party Information

Name: _____ Relation to Pt: _____
□ Married □ Single □ Divorced SSN: _____ DOB: _____
Home Address: _____

_____
No. of years at address: _____
Home phone: _____ Cell phone: _____ Work: _____
Email: _____
Employer: _____ Occupation: _____
Spouse's Name: _____ DOB: : _____
Spouse's Cell phone: _____ Spouse's SSN: _____
Email: _____
Spouse's Employer: _____ Occupation: _____

Primary Dental Insurance Information

Insured's Name: _____ Relation to Pt:_____
SSN: _____ Insured's Birthday: _____
Insured's Employer: _____
Employer Address: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Group Number (Plan, local or policy No.): _____

Health History

Medical History

(please check if patient has, or has had...)

□ AIDS/HIV Infection
□ Alcoholism
□ Angina/Chest Pain
□ Arthritis
□ Asthma/Breathing Problems
□ Blood Disease
□ Cancer/Tumors
□ Cold Sores
□ Diabetes
□ Drug Addiction/Use
□ Emotional Problems
□ Endocrine Problems
□ Epilepsy
□ Excessive Bleeding
□ Heart Problems
□ Hepatitis A, B or C
□ High/Low Blood Pressure
□ Intestinal Problems
□ Joint Swelling
□ Kidney Problems
□ Liver Problems
□ Lung Problems
□ Rheumatic Fever
□ Thyroid Problems
□ Tonsils Removed
□ Tuberculosis

Please explain all checked responses: _____
List any allergies: _____
List any medications: _____
For Female: Age of First Menstrual Cycle:_____

Dental History

(please check if patient has, or has had...)

□ Any injuries to face, mouth or teeth?
□ Thumb, finger or lip sucking habit?
□ Continuing □ Discontinued
□ Mouth breathing when asleep, awake?
□ Any known missing permanent teeth?
□ Any known extra permanent teeth?
□ Any teeth removed by extraction?
When? _____
□ Is there a tongue thrust problem?
□ Any clenching/grinding of teeth?
□ Day □ Night □ Both
□ Any pain, popping or locking on or closing jaw movements?
□ Frequent Headaches?
□ Any muscle tenderness or stiffness in jaw or neck area?
□ Any ringing in ear or dizziness?
□ Any previous treatment for TMJ problems?

Please explain all checked responses: _____
_____
_____

Please list your chief concern(s) and what you would like treatment to accomplish:
_____
_____
_____

Has patient ever been □ evaluated or □ treated by any previous orthodontist? If yes, complete below.
Orthodontist: _____ Date last seen: _____
Address/City: _____
_____
Type of Treatment: _____

SIGNATURE: _____ Date: _____