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Fishkill, NY 12524
897-5500

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www.RandRorthodontics.com

1145 Route 55, Lexington Park
LaGrangeville, NY 12540
471-1186

Thank you for taking the time to provide us with this essential information. It will be used each time we select the safest and most effective means of providing you with dental care. Of course, all information on this form is completely confidential.

Patient's Name ______ Nickname ______ Age ______

Birthdate ______ Sex ______ Height ______ Weight ______ Telephone Number ______ Cell Phone Number ______

Home Address ______ City ______ State ______ Zip ______

Hobbies ______ Sports ______ Musical Instrument ______

Family Dentist ______ Family Physician ______

Whom may we thank for referring you? ______

Person responsible for payment? ______

Billing Address ______

****CHILDREN AND ADOLESCENTS ONLY****

Father's Name ______ Email Address ______

Employer/Division ______ Local/Daytime/Business Phone ______

Occupation ______ Cell Phone ______ Daytime/Business Phone ______

S.S.# ______ Drivers License #/State ______ Birthdate ______

Insurance Company ______ Group # ______ Orthodontic Coverage Yes ☐ No ☐

Mother's Name ______ Email Address ______

Employer/Division ______ Local/Daytime/Business Phone ______

Occupation ______ Cell Phone ______ Daytime/Business Phone ______

S.S.# ______ Drivers License #/State ______ Birthdate ______

Insurance Company ______ Group # ______ Orthodontic Coverage Yes ☐ No ☐

Name and address of patient's school ______

______ Grade ______

****ADULT PATIENTS ONLY****

Employer/Division ______ Local ______ Email Address ______

Occupation ______ Cell Phone ______ Daytime/Business Phone ______

S.S.# ______ Drivers License #/State ______ Birthdate ______

Insurance Company ______ Group # ______ Orthodontic Coverage Yes ☐ No ☐

Spouse's Name ______ Email Address ______

Employer/Division ______ Local ______ Daytime/Business Phone ______

Occupation ______ Cell Phone ______ Daytime/Business Phone ______

S.S.# ______ Drivers License #/State ______ Birthdate ______

Insurance Company ______ Group # ______ Orthodontic Coverage Yes ☐ No ☐

DENTAL HISTORY

1. When was your last dental exam? ______
2. Have you ever had orthodontic treatment or been treated for a bad bite? .... Yes ☐ No ☐
3. Have you ever had periodontal or gum disease? .... Yes ☐ No ☐
4. Have any family members had orthodontic treatment? .... Yes ☐ No ☐
5. Any serious injury to face or mouth? .... Yes ☐ No ☐
6. Are you aware of any clicking, popping or grating noises in your jaw? .... Yes ☐ No ☐
7. Do you clench or grind your teeth? .... Yes ☐ No ☐
8. Have you noticed lumps, sores or irritated areas in your mouth? .... Yes ☐ No ☐
9. Any problem chewing, swallowing, or speaking? .... Yes ☐ No ☐
10. Have you ever been treated for problems of your jaw joint or for facial muscle spasm? .... Yes ☐ No ☐
11. Do you have either of the following habits: thumbsucking? .... Yes ☐ No ☐
    mouthbreathing? .... Yes ☐ No ☐
12. What do you wish to gain through orthodontic treatment? ______
    ______
13. Additional information we should know: ______
    ______

Please complete second page (over)

MEDICAL HEALTH HISTORY

1. Please describe your present health: .... Excellent { } Good { } Fair { } Poor { }
2. Has your health CHANGED in the last year? .... Yes { } No { }
3. Have you ever been HOSPITALIZED for illness or surgery? .... Yes { } No { }
   Please describe: ____
   ____
4. Has a doctor treated you for any condition in the last two years? .... Yes { } No { }
   Please describe: ____
   ____
5. Are you ALLERGIC to any drugs or other substances? .... Yes { } No { }
   Please list: ____
   ____
6. Have you ever experienced BLEEDING that was difficult to stop? .... Yes { } No { }
7. Has anyone in your family ever had DIABETES? .... Yes { } No { }
8. Are you required to restrict your work or ACTIVITY? .... Yes { } No { }
9. Is your DIET restricted or specially prescribed? .... Yes { } No { }
10. Are you taking any MEDICATIONS (aspirin, vitamins, hormones, etc.)? .... Yes { } No { }
    If so, please list them with dosages: ____
    ____
    ____

PLEASE INDICATE YES OR NO FOR ANY CONDITION, EVEN IF YOU NO LONGER HAVE IT.

Heart Trouble .... Yes { } No { }
Heart Murmur .... Yes { } No { }
Heart Surgery .... Yes { } No { }
Rheumatic Fever .... Yes { } No { }
Congenital Heart Lesions/Defects .... Yes { } No { }
Heart Pacemaker .... Yes { } No { }
Heart Valve Prosthesis .... Yes { } No { }
Heart Attack .... Yes { } No { }
High Blood .... Yes { } No { }
Pressure .... Yes { } No { }
Low Blood Pressure ...... Yes { } No { }
Hardening of Arteries .... Yes { } No { }
Artificial Joints .... Yes { } No { }
Shortness of Breath on Mild Exertion .... Yes { } No { }
Chest Pains on Mild Exertion .... Yes { } No { }
Psychiatric Care .... Yes { } No { }
Hay Fever .... Yes { } No { }
AIDS .... Yes { } No { }
Major Surgery .... Yes { } No { }

Hepatitis .... Yes { } No { }
Jaundice .... Yes { } No { }
Diabetes .... Yes { } No { }
Kidney Disease .... Yes { } No { }
Liver Disease .... Yes { } No { }
Asthma .... Yes { } No { }
Lung Disease .... Yes { } No { }
Tuberculosis .... Yes { } No { }
Bronchitis .... Yes { } No { }
Frequent Colds/ Sore Throats .... Yes { } No { }
Ankles Swell .... Yes { } No { }
Sinus Trouble .... Yes { } No { }
Fainting .... Yes { } No { }
Ulcers .... Yes { } No { }
Stroke .... Yes { } No { }
Scarlet Fever .... Yes { } No { }
Venereal Disease .... Yes { } No { }
Tonsil Problems .... Yes { } No { }
Adenoid Problems .... Yes { } No { }
Anemia/Blood Disease .. Yes { } No { }
High Fevers .... Yes { } No { }

Emotional Problems or Tension .... Yes { } No { }
Often Thirsty .... Yes { } No { }
Frequent Urination .... Yes { } No { }
Often Fatigued .... Yes { } No { }
Frequent Headaches ..... Yes { } No { }
Heavy Smoker .... Yes { } No { }
Nervous/Anxious .... Yes { } No { }
Depressed/Unhappy ..... Yes { } No { }
Recent Weight Loss ...... Yes { } No { }
Emphysema .... Yes { } No { }
Epilepsy .... Yes { } No { }
Swollen Glands .... Yes { } No { }
Nasal Obstructions .... Yes { } No { }
Immune System Problems .... Yes { } No { }
Arthritis .... Yes { } No { }
Hives/Rash .... Yes { } No { }
Thyroid/Parathyroid Disorders .... Yes { } No { }
Tumors/Growths .... Yes { } No { }
Cancer Treatment .... Yes { } No { }
Recurrent Illness .... Yes { } No { }

IF FEMALE, ARE YOU:

On Birth Control Pills ..... Yes { } No { }   In or Past Menopause ... Yes { } No { }   Pregnant .... Yes { } No { }

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

____
____
____

Please advise us of any health changes at any appointment.

PATIENT'S SIGNATURE: ______________________________ DATE: ____________

If patient is a MINOR, please print name of person completing this form.

NAME: ______________________ RELATIONSHIP TO PATIENT ______________________

SIGNATURE: ______________________

Reviewed By: ______________________