Welcome to F&S Orthodontics and Periodontics

Function and Smile Confidently

Patient Information

Full Name: _____ Preferred Name: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: ❑ H ❑ C _____ Email: _____ SSN: _____

Employer: _____ Work Phone: _____ How long employed: _____

Spouse's Name: _____ ❑ Not Married Phone: _____ Spouse Birth Date: _____

Spouse's Employer: _____ Work Phone: _____ Spouse's SSN: _____

Dentist Name: _____ Date of last dental cleaning: _____

How did you hear about us?: ❑ Dentist ❑ Google ❑ Friend/Family Whom may we thank? _____

Send appointment reminders by: ❑ Text ❑ E-mail

Dental Insurance Information Only

❑ Not covered by dental insurance (If no insurance, skip to next section)

Please provide us with your insurance card(s) so we can make a copy

Policy Holder Name: _____ Insurance Company Name: _____

Group Number: _____ ID/Policy Number (may be SSN): _____

Insurance Mailing Address (back of card): _____

Covered by secondary dental insurance? ❑ Yes ❑ No

Policy Holder Name: _____ Insurance Company Name: _____

Group Number: _____ ID/Policy Number (may be SSN): _____

Insurance Mailing Address (back of card): _____

Medical and Dental History

Main reason you contacted our office for an exam: _____

_____

Have you ever been examined by an orthodontist/periodontist before? ❑ Yes ❑ No

Did you pursue treatment? ❑ Yes ❑ No

Please explain: _____

_____

Medical and Dental History Continued

Do you have any history of the following?
- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, or heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood Transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Are you allergic to or reacted adversely to any of the following?
- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics (“Novocain”)
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other: _____

Are you taking any of the following?
- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medication
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medication
- ❑ Other: _____
  _____

Do you have any history of the following?
- ❑ Multiple cavities
- ❑ Teeth extracted
- ❑ Teeth abscessed
- ❑ Gum disease
- ❑ Nail or lip biting or thumb sucking
- ❑ Tongue thrust
- ❑ Poor dental hygiene
- ❑ Mouth breathing more than nose breathing
- ❑ Tonsils and/or adenoids removed
- ❑ Pain or ringing from ears
- ❑ Frequent ear infections, sinusitis, or swollen glands
- ❑ Need to take antibiotics before dental treatment
- ❑ Automobile accident causing dental trauma
- ❑ Obstructive sleep apnea
- ❑ Snoring or difficulty sleeping

Do you have any history of the following issues related to the Temporomandibular Joint (TMJ)?
- ❑ TMJ problems
- ❑ Clicking, popping, or noise from the jaw during opening or closing
- ❑ Teeth clenching or grinding
- ❑ Pain upon wide opening, yawning, or biting hard foods
- ❑ Frequent neck, shoulder, or back pain
- ❑ Injuries to teeth, chin, head, or face (falls, blows, etc.)
- ❑ Prosthetic joint replacement of the TMJ

Females:
- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

Is there anything else you would like us to know about you? _____

_____

_____

Signature of Patient: _____ Date: _____