F&S

Welcome to F&S Orthodontics and Periodontics
Function & Smile Confidently

Patient Information (Adult)

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

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

Phone: ❑H ❑C _____ Email: _____

SSN: _____ Employer: _____ Work Phone: _____

Dentist Name: _____ Send appointment reminders by: ❑ E-mail ❑ Text

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

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

Whom may we thank for referring you to our office? _____

Dental Insurance Information Only

❑ Not covered by dental insurance (If no insurance, skip to medical history 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: _____

Insurance Mailing Address (back of card): _____

Covered by Secondary Insurance? ❑ Yes ❑ No

Policy Holder Name: _____ Insurance Company Name: _____

Group Number: _____ ID/Policy Number: _____

Insurance Mailing Address (back of card): _____

Medical History

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

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

Are you allergic or have you 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: _____
_____

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

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: _____

_____

Do you have any history of the following?

❑ Multiple cavities
❑ Teeth extracted
❑ Teeth abscessed
❑ Gum disease
❑ Nail or lip biting or thumb sucking
❑ 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 difficultly 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

Physician's Name: _____ Phone Number: _____

Do you have any disease, condition or problem not listed above? _____

_____

Please add anything else you would like us to know about yourself: _____

_____

Signature of Patient: _____ Date: _____