Jady Chiakowsky
ORTHODONTICS

Patient Information

Name _____ _____
Last First Middle Marital Status

Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____
Street City State Zip

Nickname _____ Birthdate _____ Age ___ Sex ____ Social Security # _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name (if applicable) _____
Last First Middle

Spouse's Employer _____ Occupation _____ Years Employed _____

Spouse's Birthdate _____ Work Phone _____

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

Is there any other party other than you, or your spouse that is responsible for the account Y / N? (please don't include insurance)

If so, please give their name and phone number _____

Primary Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ ID Number _____

Union/Local Number _____ Group Number _____

Insurance Co. Address _____

Insurance Co. Phone Number _____ Insured's Phone Number _____

Secondary Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ ID Number _____

Union/Local Number _____ Group Number _____

Insurance Co. Address _____

Insurance Co. Phone Number _____ Insured's Phone Number _____

Please fill out this brief questionnaire so that we may address all of your concerns.

1. **Have you ever been examined by an orthodontist before?** _____
2. **What specific concerns do you have about your teeth and/or bite?** _____
3. **Has your dentist ever expressed concern regarding the position of your teeth and/or bite? If yes, please explain:**
4. **Are there any orthodontic appliances or dental procedures that you prefer not to have as part of your orthodontic treatment? If yes, please explain:** _____
5. **Please provide us with any other information you feel is important for us to consider.** _____

Medical History

All information is for our records only, and will be held in strict confidence.

Please circle Y (yes) or N (no) to the following questions. Your answers are necessary for us to deliver appropriate care.

Y☐ N☐ Are you in excellent health?
Y☐ N☐ Has there been any significant change in your general health in the last year?
Y☐ N☐ Are you currently being treated by a physician for any reason? If so, what is being treated? _____

_____

Y☐ N☐ Have you had a serious illness or been hospitalized in the last 5 years? If so, for what? _____

_____

Y☐ N☐ Are you currently taking any medication? If so, please list the medication and reason: _____

_____

Do you have any of the following conditions?

Y☐ N☐ Latex allergy
Y☐ N☐ Allergy to Penicillin or other antibiotics
Y☐ N☐ Allergy to Nickel or other metals
Y☐ N☐ Allergy to Sulfa drugs
Y☐ N☐ Allergy to Aspirin, Ibuprofen, or Tylenol
Y☐ N☐ Allergy to Local anesthetics
Y☐ N☐ Allergy to Codeine or other narcotics
Y☐ N☐ Allergy to other medication _____
Y☐ N☐ Asthma
Y☐ N☐ Respiratory problems, emphysema
Y☐ N☐ Sinus troubles
Y☐ N☐ Tuberculosis
Y☐ N☐ Persistent Cough
Y☐ N☐ Frequent colds or sore throats
Y☐ N☐ Diabetes
Y☐ N☐ Thyroid or endocrine problem
Y☐ N☐ Hepatitis, jaundice or liver disease
Y☐ N☐ HIV or AIDS
Y☐ N☐ Anemia
Y☐ N☐ Abnormal blood clotting
Y☐ N☐ High/Low Blood pressure
Y☐ N☐ Birth Defects

Y☐ N☐ Cardiovascular disease (heart trouble, heart attack, angina, arteriosclerosis, or stroke)
Y☐ N☐ Damaged or artificial heart valves
Y☐ N☐ Heart murmur
Y☐ N☐ Rheumatic heart disease
Y☐ N☐ Arthritis or other joint problems
Y☐ N☐ Do you require premedication prior to invasive dental procedures?
Y☐ N☐ Depression or anxiety
Y☐ N☐ Attention deficit disorder
Y☐ N☐ Other mental health condition
Y☐ N☐ Fainting spells
Y☐ N☐ Epilepsy or other neurological disorder
Y☐ N☐ Migraine headaches
Y☐ N☐ Bone fractures or trauma to the face or jaw
Y☐ N☐ Osteoporosis
Y☐ N☐ Stomach ulcers
Y☐ N☐ Gastrointestinal disorder
Y☐ N☐ Tumor (Cancerous or benign)
Y☐ N☐ Radiation therapy or chemotherapy
Y☐ N☐ Females: are you pregnant?
Y☐ N☐ Vision, hearing, or speech difficulties?

Y☐ N☐ Do you have any other medical condition not listed above that you think we should know about? _____

_____

Dental and TMJ History

Name of your dentist: _____ Approximate date of last dental exam: _____

Y☐ N☐ Previous orthodontic treatment or retainer
Y☐ N☐ Chipped or injured permanent teeth
Y☐ N☐ Jaw fractures, cyst, or mouth infections
Y☐ N☐ Previous root canal treatment
Y☐ N☐ Periodontal (gum) disease
Y☐ N☐ Periodontal therapy including gum surgery
Y☐ N☐ Loose or shifting permanent teeth
Y☐ N☐ Teeth that irritate tongue, cheeks, or lips
Y☐ N☐ Problems with food stuck in between teeth
Y☐ N☐ Thumb or finger sucking habit
Y☐ N☐ Mouth breathing, sleep apnea, or snoring
Y☐ N☐ Any prior negative dental experiences?

Y☐ N☐ Have you had a prior evaluation for "TMJ" problems?
Y☐ N☐ Have you been treated for "TMJ" with a "splint" or jaw surgery?
Y☐ N☐ Do you have a history (past or present) of clicking or popping of the jaw joint? If Yes: ☐Right ☐Left ☐Both
Y☐ N☐ History (past or present) of jaw locking?
Y☐ N☐ History (past or present) of jaw joint pain?
Y☐ N☐ Soreness or tightness of the facial muscles?
Y☐ N☐ Frequent headaches
Y☐ N☐ Limited jaw movement or difficulty chewing
Y☐ N☐ Do you have a history (past or present) of clenching or grinding your teeth?
Y☐ N☐ Is all dental work complete at this time?

I certify that I have completed these medical/dental history forms to the best of my knowledge. I will not hold Dr. Chiakowsky or any member of his staff responsible for errors or omissions that I might have made in completing this form. By my signature below I authorize insurance benefits payable directly to Dr. Chiakowsky. Dr. Chiakowsky may release all information necessary to secure payment. I authorize the use of this signature on all insurance submissions. I understand that a confidential credit report might be obtained –however, this will NOT show as an inquiry on my credit report.

_____ _____

Signature of Patient Date

Submit