Jady Chiakowsky
ORTHODONTICS

Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Nickname _____ Birthdate _____ Age _____ Sex _____

If patient is a minor, give parent or guardian's name(s) _____

What school does your child attend? _____

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

Responsible Party Information

Name _____
Last First Middle Relationship to patient

Home Phone _____ Work Phone _____ Birthdate _____ Marital Status _____

Address _____
Street City State Zip

Mailing Address if Different from above _____

How Long at this address? _____ Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ Years employed _____

Spouse's Name _____ Birthdate _____ Relationship to patient _____ Work Phone _____

Spouse's Employer _____ Occupation _____ Years employed _____

Insurance Information

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

Insurance Company _____ Group Number _____

Union Local Number _____ Card ID Number _____

Insurance Company Address _____ Phone Number _____

Insured's Employer _____

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

Insurance Company _____ Group Number _____

Union Local Number _____ Card ID Number _____

Insurance Company Address _____ Phone Number _____

Insured's Employer _____

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

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

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.

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

_____

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

_____

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

_____

Do you have any of the following conditions?

☐ ☐ Latex allergy
☐ ☐ Allergy to Penicillin or other antibiotics
☐ ☐ Allergy to Nickel or other metals
☐ ☐ Allergy to Sulfa drugs
☐ ☐ Allergy to Aspirin, Ibuprofen, or Tylenol
☐ ☐ Allergy to Local anesthetics
☐ ☐ Allergy to Codeine or other narcotics
☐ ☐ Allergy to other medication_____
☐ ☐ Asthma
☐ ☐ Respiratory problems, emphysema
☐ ☐ Sinus troubles
☐ ☐ Tuberculosis
☐ ☐ Persistent Cough
☐ ☐ Frequent colds or sore throats
☐ ☐ Diabetes
☐ ☐ Thyroid or endocrine problem
☐ ☐ Hepatitis, jaundice or liver disease
☐ ☐ HIV or AIDS
☐ ☐ Anemia
☐ ☐ Abnormal blood clotting
☐ ☐ High/Low Blood pressure
☐ ☐ Birth Defects
☐ ☐ Cardiovascular disease (heart trouble, heart attack, angina, arteriosclerosis, or stroke)
☐ ☐ Damaged or artificial heart valves
☐ ☐ Heart murmur
☐ ☐ Rheumatic heart disease
☐ ☐ Arthritis or other joint problems
☐ ☐ Do you require premedication prior to invasive dental procedures?
☐ ☐ Depression or anxiety
☐ ☐ Attention deficit disorder
☐ ☐ Other mental health condition
☐ ☐ Fainting spells
☐ ☐ Epilepsy or other neurological disorder
☐ ☐ Migraine headaches
☐ ☐ Bone fractures or trauma to the face or jaw
☐ ☐ Osteoporosis
☐ ☐ Stomach ulcers
☐ ☐ Gastrointestinal disorder
☐ ☐ Tumor (Cancerous or benign)
☐ ☐ Radiation therapy or chemotherapy
☐ ☐ Females: are you pregnant?
☐ ☐ Vision, hearing, or speech difficulties?

☐ ☐ 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: _____

☐ ☐ Previous orthodontic treatment or retainer
☐ ☐ Chipped or injured permanent teeth
☐ ☐ Jaw fractures, cyst, or mouth infections
☐ ☐ Previous root canal treatment
☐ ☐ Periodontal (gum) disease
☐ ☐ Periodontal therapy including gum surgery
☐ ☐ Loose or shifting permanent teeth
☐ ☐ Teeth that irritate tongue, cheeks, or lips
☐ ☐ Problems with food stuck in between teeth
☐ ☐ Thumb or finger sucking habit
☐ ☐ Mouth breathing, sleep apnea, or snoring
☐ ☐ Any prior negative dental experiences?
☐ ☐ Have you had a prior evaluation for "TMJ" problems?
☐ ☐ Have you been treated for "TMJ" with a "splint" or jaw surgery?
☐ ☐ Do you have a history (past or present) of clicking or popping of the jaw joint? If Yes: Right☐ Left☐ Both☐
☐ ☐ History (past or present) of jaw locking?
☐ ☐ History (past or present) of jaw joint pain?
☐ ☐ Soreness or tightness of the facial muscles?
☐ ☐ Frequent headaches
☐ ☐ Limited jaw movement or difficulty chewing
☐ ☐ Do you have a history (past or present) of clenching or grinding your teeth?
☐ ☐ 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 Parent/Guardian Date

Submit