ROSENZWEIG ORTHODONTICS
Central Oregon's Smile Specialists

Date_____

Patient Information

Name_____
Last First Middle

Sex_____ Age_____ Birthdate_____ Social Security #_____

Address _____
Street City Zip

Home Phone_____ Cell Phone_____ E-mail address_____

Employed by_____ Business Phone_____

Spouse's name (if applicable)_____

General Dentist_____ Physician_____

Dental Specialist (i.e. Periodontist, Oral Surgeon, etc)_____

Names of any other family members treated in our office? _____

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

What are your chief concerns regarding your orthodontic condition? (Overbite, crowding, etc.)

_____

_____

Dental Insurance Information

Insured's Name_____

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

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____

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

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Medical History

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please select Yes or No (If Yes, please fill in details)

☐Yes ☐ No Are you taking any medication?

☐Yes ☐ No Are you allergic to any medication?

☐Yes ☐ No Are you allergic to metals (i.e. nickel) or latex?

☐Yes ☐ No Do you have a history of a major illness?

☐Yes ☐ No Have you had any major operations?

☐Yes ☐ No Have you ever been involved in a serious accident?

Select any of the medical conditions below that you have had or currently have.

☐Abnormal bleeding/Hemophilia	☐Diabetes	☐Hepatitis/Liver problems	☐Pneumonia
☐Anemia	☐Dizziness	☐Herpes	☐Prolonged Bleeding
☐Arthritis	☐Epilepsy	☐High Blood Pressure	☐Radiation/Chemotherapy
☐Asthma or Hayfever	☐Gastrointestinal Disorders	☐HIV / Aids	☐Rheumatic Fever
☐Bone Disorders	☐Heart Problems	☐Kidney problems	☐Tuberculosis
☐Congenital Heart Defect	☐Heart Murmur	☐Nervous Disorders	☐Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Dental History

Dentist _____Date of last visit_____

☐Yes ☐ No Have you ever seen an orthodontist? If yes, who and when? _____

☐Yes ☐ No Is there anything about the appearance of your teeth or smile that is of specific concern? _____

☐Yes ☐ No Are your teeth crowding or developing spaces? _____

☐Yes ☐ No Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _____

☐Yes ☐ No Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____

☐Yes ☐ No Do you/would you have problems chewing gum? _____

☐Yes ☐ No Do you/would you have problems chewing bagels or other hard foods? _____

☐Yes ☐ No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

☐Yes ☐ No Are you aware of clenching your teeth? _____

☐Yes ☐ No Have you ever been told you grind your teeth? _____

☐Yes ☐ No Do you have problems with your jaw joint? (pain sounds, limited opening, locking, popping) _____

☐Yes ☐ No Do you have tension headaches or a history of migraines? _____

☐Yes ☐ No Do you wear or have you ever worn a bite appliance? _____

☐Yes ☐ No Have you ever lost or chipped any teeth? _____

☐Yes ☐ No Have there been any injuries to the face, mouth or teeth? _____

☐Yes ☐ No Are you currently experiencing any dental pain or sore teeth? _____

☐Yes ☐ No Do your gums bleed when you brush? _____

Please note any other factors that are relevant to your dental health. _____

_____

Authorization

I authorize the release of medical and dental information to insurance carriers, other health care providers in my dental care, and the use of records by Dr. Rosenzweig for teaching purposes or scientific publication.

In the future, please advise the doctor of any changes in your medical or dental health while under care in this office.

Signature: _____ Date: _____

Reset