Welcome!

DATE:_____

Mr./Mrs./Miss./Ms. /Dr. Name_____
(Please circle) First Middle Last
Age _____ Birthdate _____ SS#_____ Sex: M_____ F_____

Home Address _____
Street City State Zip
Home Phone #_____Cell Phone #_____
E-mail address_____ Text message reminder? Y/N
(please indicate above if you'd like email and/or text message reminders of your appointments)

Employer_____Phone_____City/State_____

Spouse Name_____Birthdate_____SS#_____
Employer _____Work phone #_____Cell#_____

Any family member treated at Falls Orthodontics?_____
Who may we thank for referring you? Or how did you get our name?_____

Medical History-Please read very carefully & mark YES or NO to the following questions.

YES NO Birth defects or hereditary problems?
YES NO Bone fractures, any major accidents?
YES NO Rheumatoid or arthritic conditions?
YES NO Endocrine or Thyroid problems
YES NO Kidney problems?
YES NO Diabetes?
YES NO Cancer or been treated for a tumor?
YES NO Stomach ulcer or hyperacidity?
YES NO Polio, mononucleosis, tuberculosis, pneumonia?
YES NO Problems of the immune system?
YES NO Hepatitis, jaundice or liver problem?
YES NO AIDS or HIV Positive?
YES NO Sexually transmitted disease?
YES NO Fainting spells, seizures, epilepsy or Neurologic disease?
YES NO History of speech issues?
YES NO Hayfever, asthma, sinus trouble, hives?
YES NO Allergies or drug reactions? Describe:_____
YES NO Are you or have you in the past taken medication to prevent osteoporosis?
YES NO Do you currently have or had a substance abuse problem?
YES NO Other physical problems or symptoms? Describe;_____
YES NO Are you in good health? Date of most recent physical exam?_____
YES NO Being treated by another health care prof? For:_____

YES NO Mental health or behavioral problems?
YES NO Vision, hearing, tasting or speech difficulties?
YES NO Loss of weight recently, poor appetite?
YES NO Excessive bleeding, black & blue tendency, anemia or bleeding disorder?
YES NO High or low blood pressure?
YES NO Easily tired?
YES NO Chest pain, shortness of breath or swelling ankles?
YES NO Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, Arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
YES NO Skin disorder?
YES NO Do you have normal & good diet?
YES NO Frequent headaches, colds or sore throats?
YES NO Eye, ear, nose, throat condition?
YES NO Tonsil or adenoid conditions?
YES NO Are you taking medication, nutrient supplements or non prescription medicine? Please name them:_____
_____
YES NO Prescription use of bis-phosphonate? _____
YES NO Hospitalized/Operation (s)_____
_____

******FEMALE PATIENT*******
YES NO Are you pregnant?
YES NO Are you taking birth control pills?
YES NO Are you anticipating becoming pregnant?

General Dentist:_____last cleaning date_____
panoramic x ray taken?_____current with restorative?_____ decay?_____appointment date_____

YES NO Past injured permanent teeth? date:_____replaced w/filling?_____crown?_____removed?_____
YES NO Aware of loose fillings: _____, broken_____missing _____ scheduled repair appointment_____
YES NO Have you had any serious trouble associated with any previous dental treatment?_explain:_____
_____date_____
YES NO "Gum Boils" frequent canker sores_____, cold sores?_____do you take RX_____
YES NO Mouth breathing habit_____, snoring,_____ difficulty in breathing?_____wear C-pap/Bi-pap_____
YES NO History of supernumerary (extra)_____removed?_____congenitally missing teeth?_____replaced_____
YES NO Permanent teeth been removed?_____Wisdom Teeth_____date/age_____Dentist/OS_____

Periodontal

YES NO Have you ever had periodontal (gum) treatment?_Periodontist:_____ last treatment_____
YES NO Bleeding gums_____, bad taste,_____ mouth infections?_____currently taking RX_____

Endodontic

YES NO Teeth/Tooth sensitive to hot _____or cold_____ teeth throb/ ache?_____
YES NO "Dead Teeth"/ root canal treatment?_____date_____Dentist_____

Orthodontic

YES NO Have you ever had orthodontic treatment: Appliances_____
How long was treatment: _____ retainer_____age started_____Orthodontist_____
YES NO Any teeth or your bite irritating cheek_____, lip,_____ tongue,_____ palate?_____
YES NO Jaw fractures/surgery_____date:_____, cysts, _____date_____
YES NO Food impaction between teeth?_____Dentist aware_____recommend ?_____
YES NO Concerned about spacing_____, crooked/crowding_____, protruding teeth?_____
YES NO Concerned about under developed jaw?_____Over developed jaw?_____
YES NO Past thumb sucking habit_____, Until age_____self stop_____Dentist intervene_____
YES NO Abnormal swallowing habit (tongue thrusting)?_____appliance placed?_____age_____
YES NO Tooth grinding_____ jaw clenching_____ clicking_____ locking_____wear splint?_____how ong_____
YES NO Ringing in the ears?_____First noticed/date/age_____
YES NO Have you ever been treated for "TMD"/TMJ issues: Care Giver_____
Date:_____Treatment:_____
YES NO Currently are you experiencing jaw pain? 0 = no pain, 10= severe pain: Today=_____Past=_____
Frequency of TMD pain: daily_____, 1-2 X weekly_____,1-2 X monthly _____other:_____
Is there a pattern related to pain occurrence? Upon waking _____ Morning_____ Afternoon_____ Evening_____
After Eating_____how long are you in pain?_____ taking RX_____
YES NO Difficulty chewing _____how long_____,Right Joint_____Left Joint_____Both_____
YES NO Is there any history of falls_____ accidents_____injuries to face/head_____date_____
YES NO has any family member had jaw surgery?___ Advance ____Reduce _____Upper ____Lower _____

I give permission, release and authorize:
Cheryl K Cermin, D.D.S. and qualified staff to take diagnostic records for the purpose of planning of orthodontic & or other related treatment. * The use of orthodontic records for professional consultations, research, education or publication in professional journals. * Any information from the insurance company relating to orthodontic or related treatment. *To submit insurance claims pertinent to treatment & to collect payment from the group insurance benefits otherwise payable to me. *To share this patient's treatment information with collaborating dentists and surgeon when appropriate. *This office will not be held responsible for any problems arising out of inadequate information not disclosed.

Signature of patient:_____Date:_____

Update or changes:_____initals_____Date:_____
Update or changes:_____initals_____Date:_____

Signature of Cheryl K. Cermin DDS_____ Date:_____

Falls Orthodontics Dr. Cheryl K. Cermin PO Box 887 St. Croix Falls, WI 54024