Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you.

Name_____Date_____
First Middle Last
Name you go by_____ Sex: M F Age _____ Birthdate _____

Home Address _____
Street City State Zip

Home Phone #_____E-mail address_____
(please indicate if you would like reminders of your appointments via email and/or text message)

Cell phone# _____Would you like a text reminder of your appointment? Y/N
Who we may thank for referring you_____ patient doctor advertising location

Interests: _____Grade_____School_____

Siblings_____age_____/_____age_____/_____age_____

Please list family members treated in our office._____

Father/Husband_____

Address (if different)_____

Employer_____

Employer's Address_____

Work Phone #_____

Soc. Sec. #_____Birthdate_____

Do you have ORTHODONTIC Insurance? Yes No

Mother/Wife_____

Address (if different)_____

Employer_____

Employer's Address_____

Work Phone #_____

Soc. Sec. #_____Birthdate_____

Do you have ORTHODONTIC Insurance? Yes No

I give permission, release and authorize:

… Cheryl K. Cermin, D.D.S. and qualified staff to take diagnostic records for the purpose of planning orthodontic treatment.
… the use of the orthodontic records for professional consultations, research, education or publication in professional journals.
… any information from the insurance company relating to the orthodontic treatment.
… payment to Cheryl K. Cermin, D.D.S. for the group insurance benefits otherwise payable to me.
… I authorize Cheryl K. Cermin, D.D.S. to share this patient's treatment information with collaborating dentists and surgeons when appropriate.
… I authorize Cheryl K. Cermin, D.D.S. to submit treatment information pertinent to this patient to the insurance company for billing purposes only.
… THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.

Signature of Parent or Guardian/Patient_____Date_____

Update (Initials)_____Date_____ Update (Initials)_____Date_____Update(Initials)_____Date_____

Update(Initials)_____Date_____Update(Initials)_____Date_____Update(Initials)_____Date_____

Signature of CHERYL K. CERMIN DDS_____Date_____

Falls Orthodontics Dr. Cheryl K. Cermin P.O. Box 887 St. Croix Falls, WI 54024 715-483-1505

Medical/Dental History

General Dentist_____ Phone # _____
Address_____
Street City State Zip
Last Cleaning Appointment_____ Panoramic (X-Ray) taken? _____date_____

Current DECAY Present? _____DO YOU HAVE AN APPOINTMENT SCHEDULED? _____

***WHAT IS YOUR MAIN ORTHODONTIC CONCERN?**_____

Physician _____ Phone #_____
City/State _____ Last Well Check Appointment _____

Specialist/Therapist_____Phone #_____
Address_____City_____State_____
Date of last appointment_____ Treatment: _____
Future Appointments Needed? Yes/ No If yes, reason _____

Y/ N Has the patient recently been evaluated for orthodontics? Doctor:_____ recommended_____
Y / N Has the patient had orthodontic treatment? Age: _____ Treatment _____
_____
Y / N Has the patient had any injury to the mouth, face, teeth or chin? Date/Year_____ Age_____
Please describe_____
Y / N Has the patient had any noise/pain/stiffness/difficulty opening in the jaw joint? (TMJ/TMD)_first noticed_____
Right _____Left _____Level of pain: 0 to 10_____take pain medication?_____ Due to Accident?_____
_____
Y / N Does the patient snore at night?
Y / N Have tonsils been removed? Age _____ Y / N Have adenoids been removed? Age_____
Y / N During waking hours does the patient mainly breathe through the mouth? (normally breathe thru the nose)
Y / N DOES or DID the patient have a thumb habit? Stopped at age: _____
Y / N DOES or DID the patient have a finger nail biting habit? Stopped at age:_____

Y / N Is the patient in any contact sports? Football/ Basketball/ Hockey/ Wrestling/ Gymnastics/ Soccer/ Baseball/ Softball/
Skiing/ Snowboarding/ Volleyball/_____

PLEASE CIRCLE YES OR NO IF THE PATIENT HAS OR HAD ANY OF THE FOLLOWING:

YES_____ NO	Asthma-exercise/allergy induced?_/Medicine dependant?	YES_____NO	AIDS/HIV
YES_____ NO	Abnormal bleeding	YES_____NO	Ever take any diet medication(Fen-Phen)
YES_____ NO	Hemophilia/bleeding disorder	YES_____NO	Hospitalized for any reason?
YES_____ NO	Hepatitis/jaundice/liver disease		_____
YES_____ NO	Allergic reactions to _____	YES_____NO	Blood Transfusion
	hives/ rash/ breathing…__ ____carry epi pen?_____	YES_____ NO	Severe frequent headaches
YES_____ NO	Arthritis		Meds:_____
YES_____ NO	Cancer/chemo/radiation	YES_____NO	Implants_____
YES_____ NO	Congenital heart defect	YES_____NO	Rheumatic fever/Scarlet fever
YES_____NO	Convulsions/epilepsy/seizures	YES_____NO	Kidney/Liver problems
YES_____NO	Diabetes	YES_____NO	Sinus problems
YES_____NO	Disability/Handicap: List_____	YES_____NO	Speech problems/speech therapy: _____
YES_____NO	Glaucoma	YES_____NO	Tuberculosis to_____
YES_____NO	Hearing impairment_____	YES_____NO	Venereal disease
YES_____NO	Heart murmur, Innocent? Pre medicate needed_____	YES_____NO	Need ANTIBIOTICS for dental work

YES_____NO Currently taking any medications? Please list _____
Additional medical information _____

Initial_____ Date_____ Initial_____ Date _____ Initial _____Date_____

Initial _____Date_____ Initial _____Date_____ Initial _____Date_____