Welcome!

ADULT FORM

Mr./Mrs./Miss./Ms. /Dr. Name_____
(Please circle) First Middle Last
Age _____ Birthdate_____ SS#_____ Home Phone #_____

Spouse Name:_____ Patient Cell Phone #_____E-mail address_____
Text message reminder of appointments? Yes/No Email reminder of appointments? Yes/No

Home Address _____
Street City State Zip

Employer_____Phone_____City/State_____

Will you be the responsible party for the account? Yes / No If NO, Please complete the following:

Are you a Student? Yes/ No Dental Insurance coverage? Yes/No Please provide insurance card & ID#_____
Who will be responsible for your account? _____Relationship_____
Billing Address:_____City_____State_____Zip_____
_____ I give Falls Orthodontics permission to speak to _____for account purposes.
(initial) (person who is responsible for the account)

If you were referred by a family member, friend or dentist, please let us know so we can thank them!

Name:_____ (Thank You sent_____)

Medical History- Please CIRCLE YES or NO

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 Skin disorder?
YES NO Fainting spells, seizures, epilepsy or Neurologic disease?
YES NO Frequent headaches?
YES NO History of speech issues?
YES NO Hay fever, asthma, environmental allergies, sinus trouble, hives?
YES NO Drug Allergy: _____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? _____
YES NO Hospitalized/Operation (s)_____
_____
YES NO Are you in good health? Date of most recent physical exam?_____
YES NO Being treated by another health care professional?
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 Do you have MRSA?
YES NO Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, Arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
Year:_____ Specialist_____
YES NO Sexually transmitted disease?
YES NO Do you have normal & good diet?
YES NO Do you have sleep apnea or have been told you snore?
YES NO Eye, ear, nose, throat condition?
YES NO Tonsil or adenoid conditions?
YES NO Are you taking prescription medication? Dosages/mg
Please List:_____
_____
YES NO Are you taking any NON prescription? Please list:
_____
YES NO Have you ever taken a prescription of bis-phosphonate?
_____
Any other condition or concern: _____
**********FEMALE PATIENT**********
YES NO Are you pregnant?
YES NO Are you taking birth control pills?
YES NO Are you anticipating becoming pregnant? (X-Rays)

General Dentist Name:_____ last cleaning date_____
panoramic x ray taken?_____ current with restorative?_____ decay?_____ appointment date_____

YES NO Past injured permanent teeth? Area_____ replaced w/filling?_____ crown?_____ removed?_____
YES NO Aware of loose fillings? Area:_____ 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? Prescription taken:_____ toothpaste used:_____
YES NO Mouth breathing habit - YES NO Snoring - YES NO Difficulty in breathing? - YES NO Wear C-pap/Bi-pap?
YES NO History of extra teeth? - YES NO removed? - YES NO Congenitally missing teeth? - YES NO replaced?
YES NO Permanent teeth been removed? Area:_____(or)Wisdom Teeth/Third Molars?_____date/age_____

Periodontal

YES NO Have you ever had periodontal (gum) treatment? Periodontist:_____ date last treatment_____
YES NO Bleeding gums? - YES NO Bad taste? - YES NO Mouth infections? - YES NO currently taking RX?

Endodontic

YES NO Teeth/Tooth sensitive to hot? - YES NO Sensitive to cold? - YES NO Do teeth throb/ ache?
YES NO "Dead Teeth"/ root canal treatment? Area: _____date_____Dentist_____

Orthodontic

YES NO Have you ever had orthodontic treatment? Appliance(s):_____Orthodontist:_____
How long was treatment: _____ how long wore a retainer_____still wear?_____ age started_____
YES NO Any teeth/bite **irritating** cheek? - YES NO Lip? - YES NO Tongue? - YES NO Palate?
YES NO Jaw fractures/surgery: upper or lower_____date:_____, cysts?,_____date_____
YES NO Food impaction between teeth? Area: _____Dentist aware?_____recommended treatment?_____
YES NO Concerned about spacing? Area: _____, crooked/crowding? Area:_____, protruding teeth?_____
YES NO Concerned about Upper Jaw development?,_____ YES NO Lower Jaw development?_____
YES NO Past thumb/finger sucking habit? Until age: _____ YES NO self stop? - YES NO Dentist intervene?
YES NO Abnormal swallowing habit (tongue thrusting)? YES NO appliance placed? age_____
YES NO Tooth grinding? - YES NO Jaw clenching? - YES NO Clicking? - YES NO Locking? - YES NO Pain?
YES NO Wear splint/ guard? Date/year received splint_____currently use?_____Date/year first symptoms started_____
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=_____ Right or Left
Frequency of TMD pain: daily_____, 1-2 X weekly_____,1-2 X monthly _____other:_____
YES NO 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? Date started:_____, Right Joint_____Left Joint_____Both_____
YES NO Is there any history of an accident or injury? Please explain _____date_____
YES NO Has any family member had jaw surgery?_____

Main Concern for todays visit:_____

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:_____