 **WELCOME TO OUR OFFICE** 

**Rajesh R. Patil, DDS MS**

**PATIENT INFORMATION**

Patient's name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_Sex M/F

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Home # (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell # (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_

 Information for patients for are minors:

FATHER: MOTHER:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate: Divorced Single Separated Married

Who may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your children’s names and ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Patient's dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does the patient receive regular dental checkups? Y/ N

Last dental exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last dental x-rays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone else in the family have a similar orthodontic problem? Y / N Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other dental specialists \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is patient satisfied with past dentistry? Y / N Any unfavorable dental experiences? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient currently have, or has the patient ever had any of the following? (Please circle)

Thumb/finger habit Head/neck injury Clenching/grinding

Nail biting Jaw/joint pain or head/neck pain Gum Surgery/food traps

Periodontal disease Cold sores Adult/baby/wisdom tooth extractions

Has the patient consulted an orthodontist previously?\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Patient's Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patients overall health status? Excellent / Good / Poor

Is the patient allergic to anything (drug,food,pollen)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient presently under medical care? Y / N For what/where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient currently taking any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient ever been hospitalized? Y / N When/where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Possibility of being pregnant?\_\_\_\_\_\_\_

Does the patient currently have, or has the patient ever had any of the following? (Please circle)

Adnoids removed Drug addiction Major surgery Cancer

AIDS (HIV) Epilepsy/seizures Nasal/airway problems Cosmetic Surgery

Arthritis Heart problems Sinus problems Diabetes

Asthma Hepatitis Speech problems Kidney Problems

Auto accident High blood pressure Tobacco usage Liver Problems

Bleeding disorders Immune disorders Tonsils removed Lung Problems

Tuberculosis Tubes in ears Venereal Disease

Adolescent females only: Has the patient started having menstrual cycles?(Helps determine jaw growth): \_\_\_\_\_\_\_\_\_\_

What would you like braces to help you with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*If payment plan requested, credit history may be reviewed*

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