Paventy ORTHODONTICS

Patient Information Form - Adult Patient

Patient Name (First) _____ (MI) ____ (Last) _____ (Preferred Name) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____ ☐ Male ☐ Female

SS# _____ Birth Date ___/___/___ Age _____ Email _____

Employer _____ Occupation _____

Dentist _____ Date Last Seen _____

Physician _____ Date Last Seen _____

Referred By _____

Emergency Contact ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. _____

Relationship to You _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Who is financially responsible for this account? ☐ Self ☐ Other _____

Primary Insurance Policy Holder ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

SS# _____ Birth Date ___/___/___ Employer _____ Occupation _____

Dental Insurance Carrier _____ Orthodontic Coverage? ☐ Yes ☐ No

Carrier Address _____ Carrier Phone _____ Group # _____

What are your main reasons for seeking an orthodontic evaluation? _____

Have you had a previous orthodontic evaluation? ☐ Yes ☐ No If yes, when? / Where? / Who? _____

Have you had prior orthodontic treatment? ☐ Yes ☐ No If yes, when? / Where? / Who? _____

Has a family member had prior orthodontic treatment? ☐ Yes ☐ No If yes, when? / Where? / Who? _____

Please check the box if you are concerned about any of the following:

☐ Spaced, Crooked, or Protruding Teeth
☐ Over or Under Developed Jaw
☐ Shade or Color of Teeth
☐ Shape or Size of Teeth

Are there any other dental concerns that you would like to share at this time? _____

Please complete medical and health history on reverse

Medical History

Are you currently in good health? ☐ Yes ☐ No
Do you need special assistance? ☐ Yes ☐ No
Do you chew or smoke tobacco? ☐ Yes ☐ No
Women Only: Are you pregnant? ☐ Yes ☐ No
Are you anticipating becoming pregnant? ☐ Yes ☐ No
Are you currently under the care of a physician or health care professional? ☐ Yes ☐ No Reason _____
Do you have or have you ever had a substance abuse problem? ☐ Yes ☐ No
Are you taking medication, nutrient supplements, herbal medications or non-prescription medication? ☐ Yes ☐ No
Are you taking any bisphosphate medication (Boniva. Fosamax, Zometa)? ☐ Yes ☐ No
Please list any medications or supplements you are taking: _____

Please check the box if you have allergies or reactions to any of the following:

☐ Local Anesthetics (Novocaine or Lidocaine)
☐ Aspirin
☐ Ibuprofen (Motrin, Advil)
☐ Penicillin or Other Antibiotics
☐ Sulfa Drugs
☐ Codeine or Other Narcotics
☐ Metals (Jewelry, Clothing Snaps)
☐ Latex (Gloves, Balloons)
☐ Vinyl
☐ Acrylic
☐ Other Substances _____

Please check the box if you currently have (or have had in the past), any of the following:

☐ ADD / ADHD
☐ Rhematoid Arthritis
☐ Endocrine of Thyroid Problems
☐ Kidney Problems
☐ Diabetes
☐ Cancer, Tumor, Radiation Treatment or Chemotherapy
☐ Stomach Ulcer or Hyperacidity
☐ Polio, Mononucleosis, Tuberculosis or Pheumonia
☐ AIDS or HIV Positive
☐ Hepatitis, Jaundice or Liver Problems
☐ Fainting Spells, Seizures, Epilepsy or Neurological Problems
☐ Mental Health Distrubance or Depression
☐ History of Eating Disorder (Anorexia, Bulimia)
☐ Excessive Bleeding or Bruising Tendancy, Anemia or Bleeding Disorder
☐ Vision, Hearing, Tasting, or Speech Difficulties
☐ High or Low Blood Pressure
☐ Frequent Headaches
☐ Eye, Ear, Nose or Throat Condition
☐ Hayfever, Asthma, Sinus Trouble or Hives
☐ Tonsil or Adenoid Conditions
☐ Cleft Lip / Palate
☐ Congenital Heart Defect
☐ Heart Murmur or Rheumatic Heart Disease
☐ Developmental / Learning Disability
☐ Neck or Back Problems
☐ Osteoporosis
☐ Prosthetic Implants

Do you have any other medical conditions that we should know about? _____

Dental History

Have you ever been in a motor vehicle accident? ☐ Yes ☐ No
Have you had any trauma or injury to the head, face, teeth or neck? ☐ Yes ☐ No
Have you ever had serious trouble associated with any previous dental treatment? ☐ Yes ☐ No
Have you ever been under another dentist's or dental specialist's care? ☐ Yes ☐ No
Have you ever had wisdom teeth extracted? If yes, date of extractions? _____ ☐ Yes ☐ No

Please check box if you currently have (or have had in the past), any of the following:

☐ Permanent or Supernumerary (Extra), Teeth Removed
☐ Supernumerary (Extra), Teeth or Congenitally Missing Teeth
☐ Chipped or Otherwise Injured Primary or Permanent Teeth
☐ Loose, Broken or missing Restorations (Fillings)
☐ Jaw Fractures
☐ Cysts or Mouth Infections
☐ "Dead Teeth" or Root Canals Treated
☐ Bleeding Gums, Bad Taste or Mouth Odor
☐ Periodontal "Gum" Problems
☐ Food Impaction Between Teeth
☐ History of Speech Problems / Speech Therapy (When? _____)
☐ Teeth Sensitivity to Cold or Hot - Teeth Throb or Ache
☐ Thumb, Finger or Sucking Habit (Until Age _____)
☐ Nail or Pen / Pencil Biting Habit
☐ Abnormal Swallowing Habit (Tongue Thrusting)
☐ Mouth Breathing Habit, Snoring, or Difficulty Breathing
☐ Tooth Grinding or Jaw Clenching
☐ Pain, Clicking, or Locking in Jaw or Ringing in Ears
☐ Pain or Soreness in Muscles of Face or Around Ears
☐ Difficulty in Chewing or Jaw Opening
☐ "TMD" or "TMJ" Problems
☐ "Gum Boils", Frequent Canker Sores or Cold Sores
☐ Do you have any other dental conditions that we should know about? _____

I give Dr. Paventy permission to bill insurance and directly recieve payment from my insurance carrier. I understand that I am responsible to pay all fees for services rendered above and beyond what insurance covers. I give permission for the office to take diagnostic photographs, dental impressions, and x-rays if indicated, as well as share and discuss these records with other related health care providers.

Patient Signature _____ *Date* _____