**SAINI ORTHODONTICS**
10776 Hickory Ridge Road
Columbia, MD 21044
"Getting To Know You"

# For Patients over Age 18 years

Patient's Full Name: ______________________________ Sex: __Female __Male Birth Date: ________________ Age: __________

Patient's Address: _______________________________________________ City: ____________________ State: _______________

Zip/Postal Code: _________________ Home Phone: _________________________ Cell Phone: ____________________________

Employer: _______________________________ Position: _______________________ Email: ________________________________

Ok to call you at work: __YES __NO Work Phone: ____________________________

__Single __Married __Separated __Divorced

Spouse's Name: ___________________________________________________

Spouse's Employer: ___________________________ Position: _______________________ Email: ___________________________

Ok to call you at work: __YES __NO Work Phone: _______________________

Person responsible for financial account: _____________________________ Relationship to Patient: ____________________

Address: _____________________________________ City: ____________________ State: ____________________

Zip/Postal Code: ________________________ Home Phone: ___________________________

Employer: _____________________________________ Position: _______________________ Business Phone: _______________

Dental Insurance Company: _______________________________ ID # _____________________ Group # _________________

Primary Holder's Full Name: _____________________________________ Birth Date: ____________________________

Does this policy have orthodontic benefit? __YES __NO

Secondary Dental Insurance Company: __________________________________ ID # __________________ Group# ______________

Secondary Holder's Full Name: _____________________________________ Birth Date: _______________________

Does this policy have orthodontic benefit? __YES __NO

How did you become aware of this office? _____________________________________________________________

Previous Orthodontic Experience: __Patient __Spouse __Brother __Sister __Children

**DENTIST**

Patient's Dentist: _______________________________ Last visit to DDS (months)__________ Last X-Ray (months): ____________

Address: _____________________________________________ City: ________________________ State: ______________

Zip/Postal Code: ________________ Phone: _______________________ General Oral Health: _________________

**PHYSICIAN**

Patient's Physician: _________________________________ Phone # _________________________________

**MEDICAL HISTORY**

__YES __NO Are you presently under a physician's care? If so, for what: ______________________________________

__YES __NO Have you ever been hospitalized? If so, for what: _______________________________________________

__YES __NO Has there been any change in your health this year? ____________________________________________

__YES __NO Have you ever been advised to premedicate with antibiotics for dental appointments? ________________

__YES __NO Prior adverse dental experiences Patient_____ Parent______ Siblings______

__YES __NO Operations? If so, what? _____________________________________________________________________

__YES __NO Adenoids Removed? If so, when: ______________________________________________________________

__YES __NO Tonsils Removed? If so, when: ________________________________________________________________

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS?**

__YES __NO Endocrine/Thyroid problems

__YES __NO Diabetes

__ YES __NO Heart trouble or stroke

__YES __NO Do you wear a pacemaker for your heart?

__YES __NO Heart murmur, Mitral Valve Prolapse/Rheumatic Fever

__YES __NO Do you have cardiac valve prosthesis?

__YES __NO High or low blood pressure

__YES __NO Chest pains, ankle swelling, or shortness of breath problems

__YES __NO Clotting problems, blood transfusions

__YES __NO Epilepsy or seizures, fainting

__YES __NO Glaucoma or eye disorders

__YES __NO Do you wear contacts?

__YES __NO Tested positive to the HIV virus/AIDS/STD?

__YES __NO Transplants or any artificial prosthesis

__YES __NO Medical radiation/chemotherapy treatments

__YES __NO Neurological problems

__YES __NO Depression or Anxiety

__YES __NO Sleep Apnea

__YES __NO Kidney problems, dialysis

__YES __NO Any other medical problems/operations? If yes, what: ________________________________________________

__YES __NO Hepatitis, jaundice, or liver disease

__YES __NO Arthritis, rheumatism

__YES __NO Abnormal bleeding or blood disorders

__YES __NO Stomach or duodenal ulcers

__YES __NO Asthma, allergies, respiratory

__YES __NO Tuberculosis

**ARE YOU ALLERGIC TO OR REACT ADVERSLY TO:**

__YES __NO Local Anesthetics (Novocaine)

__YES __NO Motrin, Advil (Ibuprofen), Aspirin, Tylenol

__YES __NO Barbiturates, sedatives, sleeping pills

__YES __NO Other: ____________________________________________

__YES __NO Latex, nickel

__YES __NO Penicillin, other antibiotics

__YES __NO Codeine

**ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICIATIONS?**

__YES __NO Antibiotics ________________________________________________

__YES __NO Anticoagulants (Blood Thinners) ______________________________

__YES __NO Tranquilizers _______________________________________________

__YES __NO Cortisone (steroids) _________________________________________

__YES __NO Medication for high blood pressure ___________________________

__YES __NO Medication for diabetes _____________________________________

__YES __NO Aspirin ____________________________________________________

__YES __NO Ritalin, Prozac, other _______________________________________

__YES __NO Digitalis or other heart medication ___________________________

__YES __NO Osteoporosis medicines (Bisphosphonate, etc.) ________________

__YES __NO Nitroglycerin _____________________________________________

__YES __NO Any substance abuse problem? ______________________________

__YES __NO Are you presently taking other prescription medications/nonprescription? If yes, please list: ___________________

_____________________________________________________________________________________________________________

**DENTAL HISTORY**

Any Facial/Dental Injuries? __YES __NO What kind? ____________________________________________________________

Does the Patient play a Musical Instrument? __YES __NO What kind? ___________________________

Does the Patient have difficulty closing lips or biting with front teeth? __YES __NO

Oral Habits: __Thumb sucking __Finger sucking __Nail biting __Lip biting __Mouth-breathing

__Tongue thrust __Snoring __ Use of Tobacco

Gag Reflex: __None __Moderate __Strong

Speech and other problems: __________________________________________________________________________

Who noticed the need for Orthodontic treatment first? __Patient __Spouse __Dentist Other: ________________________

Pervious Orthodontic Treatment: __YES __NO Length of Treatment ___________ Mos. _____________________

Orthodontist: __________________________________________________ Previous Orthodontic Consultation __YES __NO

**TMJ HISTORY**

| | | | | | |
|---|---|---|---|---|---|
| Any pain in joints/jaw? | __YES | __NO | Frequent Headaches? | __YES | __NO |
| Any popping or clicking of the jaw joints? | __YES | __NO | Pain/Ringing/Fullness in ear? | __YES | __NO |
| Grinding or clenching of teeth? | __YES | __NO | Pain or soreness in the eyes? | __YES | __NO |
| Is there any tightness of jaws-joints? | __YES | __NO | Neck or shoulder pain? | __YES | __NO |
| Is there any difficulty swallowing? | __YES | __NO | Difficultly in opening mouth? | __YES | __NO |

**GENERAL INFORMATION**

What do you think is wrong with your teeth? ____________________________________________________

Do your front teeth hurt the roof of your mouth or lower front gums? __YES __NO

Any irritation to your lips/tongue from irregular teeth? __YES __NO

Do you have difficultly flossing? __YES __NO

Do you have difficultly closing your mouth or biting with your front teeth? __YES __NO

If treated with braces, what are your specific expectations? ___________________________________

Are you seeking orthodontic treatment with: __Eagerness __Willingness __Complacency __Resignation __ Antagonism

**PERSON FILLING OUT PAPERWORK __Self __Other**

**For your information:**
**Some of the orthodontic appointments will infringe on school/work time.**
**Possible side effects of orthodontics – cavities, enlargement of gums, root shortening, bone loss, joint disturbances and relapse.**
**Benefits of Orthodontics – Esthetics, health, function and comfort.**

**I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes later on to this history record, I will so inform this practice. Also, I give consent for this examination/treatment and am legally authorized to do so.**

________________________________________ ______________________________________________________

REVIEWED BY DATE PATIENT'S SIGNATURE DATE