VITAGLIANO ORTHODONTICS

Just Getting to Know you

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Sex: _____ DOB: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work/Cell Phone: _____
SSN: _____
Email Address: _____
Spouse's Name (if applicable): _____
If patient is a minor:
Father's Name: _____
Mother's Name: _____
Stepparent's Name (if applicable): _____
Guardian: _____ Relationship: _____
Who is the primary person responsible for bringing the patient to appointments? _____
Whom may we thank for recommending our office? _____
Please list relatives or friends seen in our office: _____
Siblings Name: _____ DOB: _____
Name: _____ DOB: _____
What musical instrument does your child / do you play? _____
What activity does your child/ do you enjoy? _____

Responsible Party Information

Last Name: _____ **First**: _____ **Middle Initial**: ____
Birthdate: _____
Address: _____
City: _____ **State**: _____ **Zip**: _____
Home Phone: _____**Relationship to Patient**:_____
SSN: «RespSocSecNum»
Emergency contact information for
Mom: Cell: _____Work: _____
Dad: Cell: _____ Work: _____
Occupation: _____ Employer: _____
Address: _____
Work Phone: _____

Spouse's Last Name: _____ **First**: _____ **Middle Initial**: _____
Spouse's Occupation: _____ **Work Phone**: _____
Spouse's Employer: _____

Emergency Information

Nearest relative not living with you: _____
Address: _____ **Phone: _____**

Dentist Information

Dentist: _____ **Phone: _____ Date of last visit**: _____
Dentist's reason for referring: _____
Has patient consulted with another specialist? _____

Dental History

Please describe your/patients main concern with your teeth, jaw, bite or facial appearance: _____
_____
Please list close relatives who have experienced:
Orthodontic treatment: _____
Abnormal jaw growth: _____
Please mark the following that apply:
☐ Thumb sucking or Finger sucking ☐ Teeth Clenching or grinding ☐ Mouth breathing
☐ Speech Disorder ☐ Speech Therapy ☐ Tongue Thrust ☐ Nail biting ☐ Lip sucking or biting
Does patient have a speech disorder? Please describe: _____
Does patient experience Tempro-Mandibular Joint Dysfunction (clicking and pain in jaw)? _____
Please describe any injuries to head, neck, jaw, or teeth: _____
_____
Has patient had previous orthodontic care? _____

Medical History

Physician: _____ **Phone:** _____
Medical Specialist: _____
How is patient's health? _____ Patient has been hospitalized in the past 2 years (emergency room)**? _____**
Have you had any unusual reactions to any medications or other substance?
Please list substance and effects:
_____

Please check any of the following that apply:

☐ ADD / ADHD	☐ Diabetes	☐ High blood pressure	☐ Pacemaker
☐ Arthritis	☐ Drug/Alcohol dependency	☐ Hypoglycemia	☐ Painful jaw joint
☐ Artificial joint or heart valve	☐ Epilepsy/Seizures	☐ Immunodeficient disease	☐ Require Pre-medication
☐ Asthma	☐ Fainting or dizziness	☐ Kidney disease	☐ Rheumatic fever
☐ Bleeding problems	☐ Frequent headaches	☐ Latex allergy	☐ Stroke
☐ Cancer	☐ Heart disorder	☐ Liver disease	☐ Thyroid disease
☐ Cold sores	☐ Hepatitis A / B	☐ Nervous disorders	☐ Tuberculosis

Does patient have any allergies, conditions or problems that were not listed above? _____
_____
If pregnant or nursing, please indicate: _____ **Have you had extensive x-ray therapy?** _____

THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM DR. VITAGLIANO AT MY NEXT APPOINTMENT.
I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

Signature of patient or guardian**: _____** Date**: _____**