Welcome!

DATE:_____

Mr./Mrs./Miss./Ms. /Dr. Name_____
(Please circle) First Middle Last
Age _____ Birthdate _____ SS#_____ Sex: M_____ F_____

Home Address _____
Street City State Zip
Home Phone #_____Cell Phone #_____
E-mail address_____ Text message reminder? Y/N
(please indicate above if you'd like email and/or text message reminders of your appointments)

Employer_____Phone_____City/State_____

Spouse Name_____Birthdate_____SS#_____
Employer _____Work phone #_____Cell#_____

Any family member treated at Falls Orthodontics?_____
Who may we thank for referring you? Or how did you get our name?_____

Medical History-Please read very carefully & mark YES or NO to the following questions.

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 Sexually transmitted disease?
YES NO Fainting spells, seizures, epilepsy or Neurologic disease?
YES NO Any history of speech problems?
YES NO Hayfever, asthma, sinus trouble, hives?
YES NO Allergies 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? Describe;_____
YES NO Are you in good health? Date of most recent physical exam?_____
YES NO Being treated by another health care prof? 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 Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, Arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
YES NO Skin disorder?
YES NO Do you have normal & good diet?
YES NO Frequent headaches, colds or sore throats?
YES NO Eye, ear, nose, throat condition?
YES NO Tonsil or adenoid conditions?
YES NO Are you taking medication, nutrient supplements or non prescription medicine? Please name them:_____
_____
YES NO Operations? Describe:_____
YES NO Hospitalized? For_____
_____

******FEMALE PATIENT*******
YES NO Are you pregnant?
YES NO Are you taking birth control pills?
YES NO Are you anticipating becoming pregnant?

Dental History- Please read carefully & mark YES or NO to the following questions.

YES NO Chipped or otherwise injured permanent teeth? _____
YES NO Aware of loose, broken or missing restorations (fillings)?_____
YES NO Teeth sensitive to hot or cold: teeth throb or ache?_____
YES NO "Dead Teeth", root canal treatment?_____
YES NO Mouth breathing habit, snoring, difficulty in breathing?_____
YES NO History of supernumerary (extra) or congenitally missing teeth?_____
YES NO Any teeth irritating cheek, lip, tongue, palate?_____
YES NO Jaw fractures, cysts, mouth infections?_____
YES NO Have you ever had periodontal (gum) treatment?_____
YES NO Bleeding gums, bad taste, mouth infections?_____
YES NO Food impaction between teeth?_____
YES NO "Gum Boils" frequent canker sores, cold sores?_____
YES NO Have you ever had orthodontic treatment or worn a "retainer" or "bite plate"?_____
YES NO Concerned about spaced, crooked, protruding teeth?_____
YES NO Aware or concerned about under or over developed jaw?_____
YES NO Any relative with similar tooth or jaw relationships?_____
YES NO Thumb, finger, sucking habit? Until _____age_____
YES NO Abnormal swallowing habit (tongue thrusting)?_____
YES NO Any permanent teeth been removed?_____
YES NO Any wisdom tooth problems?_____
YES NO Tooth grinding, jaw clenching, clicking, locking?_____
YES NO Do you experience any pain or soreness in the muscles of your face, or around the ears?_____
YES NO Any pain in jaw or ringing in the ears?_____
YES NO Difficulty encountered in chewing or jaw opening?_____
YES NO Have you ever been treated for "TMD" problems (Your jaw joint or facial muscle pain?)_____
YES NO Have you had any serious trouble associated with any previous dental treatment?_____
YES NO Are you routinely see by a general dentist? _____

General Dentist:_____City_____
Date of most recent dental examine: _____panoramic x ray?_____
***What is your primary concern?/ Why are you here?**_____
_____

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:_____

Signature of Cheryl K. Cermin DDS_____ Date:_____
Update or changes:_____initals_____Date:_____

HISTORY FOR PATIENTS WITH TEMPROMANDIBULAR DISORDER (JAW JOINT)

YES NO Is there any history of falls, accidents or injuries to face or head?_____
What is the nature of your problem? (pain, noise, limitation of movement,_____)
Is the problem getting better, worse, or staying the same? (circle answer)
When did you first notice the problem? _____months _____years _____new problem
Degree of current TMD pain: 0 = no pain, 10= severe pain:_____
Frequency of TMD pain: daily weekly monthly semi-annually (circle answer)
Is there a pattern related to pain occurrence? Upon waking – Morning- Afternoon- Evening- After Eating
YES NO Are you taking medication for the TMD problem? If so what;_____
YES NO Have you received treatment or Physical Therapy for jaw problems? Whom:_____
What was the treatment? Bite splint-medication-Physical Therapy-Occlusal adjustment-surgery-other___
YES NO Has your jaw ever locked open or closed? When did this first occur?_____ how often?_____
YES NO Does your jaw make noise? Right or Left: _____click _____pop _____grinding ___other:_____
Any current stress factors that apply you?_____