Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. We look forward to working with you.

Name_____Date_____
First Middle Last
Name you go by_____ Sex: M F Age _____ Birthdate _____

Home Address _____
Street City State Zip

Home Phone #_____E-mail address_____
(please indicate if you would like reminders of your appointments via email and/or text message)

Cell phone#_____ Would you like a text reminder of your appointment? Y/ N

Who we may thank for referring you_____ patient doctor advertising location

Interests: _____Grade_____School_____

Siblings_____/_____/_____

Please list family members treated in our office._____

Father/Husband_____

Address (if different)_____

Employer_____

Employer's Address_____

Work Phone #_____

Soc. Sec. #_____Birthdate_____

Do you have ORTHODONTIC Insurance? Yes No

Mother/Wife_____

Address (if different)_____

Employer_____

Employer's Address_____

Work Phone #_____

Soc. Sec. #_____Birthdate_____

Do you have ORTHODONTIC Insurance? Yes No

I give permission, release and authorize:

… Cheryl K. Cermin, D.D.S. and qualified staff to take diagnostic records for the purpose of planning orthodontic treatment.
… the use of the orthodontic records for professional consultations, research, education or publication in professional journals.
… any information from the insurance company relating to the orthodontic treatment.
… payment to Cheryl K. Cermin, D.D.S. for the group insurance benefits otherwise payable to me.
… I authorize Cheryl K. Cermin, D.D.S. to share this patient's treatment information with collaborating dentists and surgeons when appropriate.
… I authorize Cheryl K. Cermin, D.D.S. to submit treatment information pertinent to this patient to the insurance company for billing purposes only.
… THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.

Signature of Parent or Guardian/Patient_____Date_____

Update (Initials)_____Date_____ Update (Initials)_____Date_____

Signature of CHERYL K. CERMIN DDS_____Date_____

Falls Orthodontics Dr. Cheryl K. Cermin P.O. Box 887 St. Croix Falls, WI 54024 715-483-1505

Medical/Dental History

General Dentist_____ Phone # _____
Address_____
Street City State Zip
Last Cleaning Appointment_____X-rays/Panoramic taken? _____

IS DECAY PRESENT?_____DO YOU HAVE AN APPOINTMENT SCHEDULED?_____

***WHAT IS YOUR MAIN ORTHODONTIC CONCERN?**_____

Physician _____ Phone #_____
Address _____ Last Well Check Appointment _____

Specialist/Therapist_____Phone #_____
Address_____
Last Appointment_____
Future Appointments Needed? Yes/No If yes, reason _____

Y/ N Has the patient been evaluated for orthodontics? Doctor: _____
Y / N Has the patient had orthodontic treatment? Age: _____ Treatment _____
Y / N Has the patient had any injury to the mouth, face, teeth or chin? Explain _____
_____ Age: _____
Y / N Has the patient had any noise/pain/stiffness/difficulty opening in the jaw joint? (TMJ/TMD)
Y / N Currently taking any medications? Please list _____
Y / N Have tonsils been removed? Date _____ Age _____
Y / N Have adenoids been removed? Date _____ Age _____
Y / N DOES the patient have a thumb habit?
Y / N DID the patient have a thumb habit? Stopped at age: _____
Y / N DOES the patient have a finger biting habit?
Y / N DID the patient have a finger biting habit? Stopped at age: _____
Y / N Does the patient mainly breathe through their mouth? (Nose is normally used)
Y / N Does the patient snore at night?
Y / N Is the patient in any contact sports? Please list _____
_____

PLEASE CIRCLE YES OR NO IF THE PATIENT HAS OR HAD ANY OF THE FOLLOWING:

YES	NO	Asthma	YES	NO	AIDS/HIV
YES	NO	Abnormal bleeding	YES	NO	Ever taken any diet medication (Fen-Phen)
YES	NO	Hemophilia/bleeding disorder			
YES	NO	Hepatitis/jaundice/liver disease	YES	NO	Blood Transfusion
YES	NO	Allergic reactions to _____ What: (hives/rash/breathing…)_____Date:_____	YES	NO	Hospitalized for any reason Why:_____ Date:_____
YES	NO	Arthritis	YES	NO	Kidney/Liver problems
YES	NO	Cancer/chemo/radiation	YES	NO	Implants
YES	NO	Congenital heart defect	YES	NO	Rheumatic fever/Scarlet fever
YES	NO	Convulsions/epilepsy/seizures	YES	NO	Sever/frequent headaches
YES	NO	Diabetes	YES	NO	Sinus problems
YES	NO	Disability/Handicap	YES	NO	Speech problems/speech therapy
YES	NO	Glaucoma	YES	NO	Tuberculosis
YES	NO	Hearing impairment	YES	NO	Venereal disease
YES	NO	Heart murmur	YES	NO	Need ANTIBIOTICS for dental work

OTHER:_____

Initial_____ Date_____ Initial_____ Date _____