RICHARDS & LEVINE ORTHODONTICS

--ADULT PATIENT INFORMATION--

Patient's Name:_____Age_____Sex_____

Social Security #:_____Date of Birth:_____

Occupation:_____

Marital Status:_____Spouse Name:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Phone Number:_____(Mobile, Home, Business-circle one)

Patient Email Address: _____

Current Dentist:_____Dentist Phone #:_____

Current Physician:_____Physician Phone #:_____

Who may we thank for referring you to our office?_____

--INSURANCE INFORMATION--

Orthodontic Insurance? Insurance Name_____

Insurance phone number:_____

Employer_____

Subscriber Name:_____ Birthdate:_____

Subscriber ID#:_____Group #:_____

PATIENT NAME:_____

--MEDICAL HISTORY--

Is the Patient in good health?_____
Have tonsils and/or adenoids been removed?_____
If presently under physician's care, state condition and duration_____
_____
Does patient have history of major illness/infectious diseases?_____
List any high fevers with childhood diseases_____
List any drugs or medications being taken and reasons_____
_____
List any allergies or drug sensitivities (e.g.. penicillin, novacaine)_____
List any learning disabilities_____
List any birth defects_____
List any psychological counseling_____
Check any of the following for which you have been treated and give age:

	Yes	No		Yes	No		Yes	No
HIV + Aids……	[ ]	[ ]	Bone Disorders……..	[ ]	[ ]	Kidney Problems……..	[ ]	[ ]
Fainting/dizziness…..	[ ]	[ ]	Pneumonia or TB…….	[ ]	[ ]	Nasal difficulty……..	[ ]	[ ]
Diabetes……..	[ ]	[ ]	Nervous Disorders…..	[ ]	[ ]	Heart Trouble……..	[ ]	[ ]
Epilepsy……..	[ ]	[ ]	Endocrine Problems..	[ ]	[ ]	Hepatitis……..	[ ]	[ ]
Rheumatic Fever……..	[ ]	[ ]	Asthma……..	[ ]	[ ]	Prolonged Bleeding…….	[ ]	[ ]
Dermatitis……..	[ ]	[ ]						

Perferred Pharmacy:_____**Phone number:**_____
_____

--DENTAL HISTORY--

Did Father have an orthodontic problem?_____**Treated?**_____
Did Mother have an orthodontic problem?_____**Treated?**_____
Do any siblings have any orthodontic problems?_____**Treated?**_____
List other family members treated in this office_____
List names and ages of other children in family_____
Face and mouth most resemble: [ ]Father [ ]Mother [ ]Neither
List any injuries to face, teeth or mouth_____
Habits: [ ]Mouth breathing [ ]Grinding teeth [ ]Thumb or finger sucking (until what age)_____
List any speech problems_____
List any musical instruments played_____
Has an orthodontist been consulted previously: [ ]Yes [ ]No Whom?_____
Does patient vomit , gag or faint easily? [ ]Yes [ ]No
Have you been informed of any missing or extra permanent teeth? [ ]Yes [ ]No_____
Is patient especially apprehensive toward dental visits? [ ]Yes [ ]No
When did patient last have dental care?_____
By Whom_____**When is next scheduled visit?**_____
What do you feel may be the cause of the orthodontic problem?_____
What would you most like to have orthodontic treatment accomplish?_____
Most Important- does the patient want orthodontic treatment? [ ]Yes [ ]No

PATIENTS NAME:_____

--AUTHORIZATIONS—

I hereby authorize Richards & Levine Orthodontics to release a copy of my records to any treating physician/dentist, insurance company or other orthodontist, who may request these records pursuant to further medical or orthodontic care or treatment, and hereby release Richards & Levine Orthodontics and staff, from any and all responsibility that may arise from their compliance with this authorization. I hereby authorize Richards & Levine Orthodontics to use any of my x-rays or photographs in medical lectures /publications and for further educational purposes. I understand the Panorex taken at my new patient exam is at no charge but if the Panorex is requested to leave our office there will be a $165 charge.

_____ _____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**

--MEDIA CONSENT--

We have a website and a Facebook page and would love to share your/your child's smile.
[ ] I do give Richards & Levine Orthodontics permission to share my photos.
[ ] I do not give Richards & Levine Orthodontics permission to share my photos.

_____ _____

DATE **PATIENT OR PARENT/GUARDIAN'S SIGNATURE**