Michael Pantos, D.M.D., P.A.

Orthodontics

Member American Association of Orthodontists

OFFICE: _____

ORTHODONTIC PATIENT INFORMATION

Patient's Name: _____ Age: _____ Birth Date: ___/___/_____Sex: ____
Last First Middle

Home Address: _____ Home Phone: _____
Street City Zip Code

Patient's Occupation or School Level: _____ Work Phone: _____

Employer or School: _____ Cell Phone: _____

Person Responsible for Account: _____ Relationship: _____ SSN: _____

Home Address: _____ Home Phone: _____
Street City Zip Code

Work Phone: _____ Cell Phone: _____ E-mail: _____

Name of person to contact if patient cannot be reached: _____ Relationship: _____ Phone: _____

Family Dentist: _____ Address: _____ Phone: _____

Date of most recent dental check-up: _____ Were the patients teeth cleaned? Yes No

Family Physician: _____ Address: _____ Phone: _____

Date of most recent physical exam: _____

How did you hear about our office? (Circle) A) Dentist B) Insurance Co. C) Phone Book D) Mailer Ad
E) Friend F) Family Member G) Other, please describe _____

If a friend referred you, whom should we thank? _____

Is patient covered by insurance for orthodontic treatment? Yes No

Primary Policy Holder's Name: _____ Birth Date: ___/___/_____

Employer: _____ SSN: _____

Insurance Company Name: _____ Group # _____ Policy # _____

Secondary Policy Holder's Name: _____ Birth Date: ___/___/_____

Employer: _____ SSN: _____

Insurance Company Name: _____ Group # _____ Policy # _____

FAMILY HISTORY (Circle as Needed)

Father's Name: _____ Living? Yes No

Mother's Name: _____ Living? Yes No

Siblings: Yes No Number of Brothers: _____ Number of Sisters: _____

Patient's Marital Status: _____ Spouses Name: _____

Patient Living With: Father Mother Spouse Self Other: _____

(Back)

MEDICAL HISTORY (Circle as Needed)

Has the patient ever had? (Please Circle)

Asthma	Yes	No	Heart Disease	Yes	No
Anemia/ Abn. Bleeding	Yes	No	Hearing Disorder	Yes	No
Blood Disease	Yes	No	Head or Face Injury	Yes	No
Bone Disorders	Yes	No	Herpes	Yes	No
Diabetes	Yes	No	Hepatitis	Yes	No
Epilepsy	Yes	No	Rheumatic Fever	Yes	No
Endocrine Problems	Yes	No	A.I.D.S./ H.I.V.	Yes	No
Emotional Problems	Yes	No	Other (describe below)	Yes	No

COMMENTS: _____

Has the patient been under the care of a physician during the past two years, other than for a routine examination?
Yes No Condition: _____

Present drugs and/or medications: _____

Birth Defects: Yes No Please list: _____

Has the patient reached puberty (menstruation, hair)? Yes No

Does the patient?

1. Have allergies to: (Please list or write N/A as needed)
   Drugs, Meds or Anesthetics: _____ Seasonal grasses: _____
   Latex (gloves, balloons etc.): _____ Food: _____
   Metals (snaps, jewelry etc.): _____ Other: _____
2. Snore when sleeping? Yes No Frequency: _____
3. Breath through mouth? Yes No Frequency: _____
4. Have frequent cold? Yes No Frequency: _____
5. Have frequent "stuffy nose"? Yes No Frequency: _____
6. Have frequent sore throat or tonsillitis? Yes No Frequency: _____
7. Have chewing or swallowing difficulty? Yes No Frequency: _____
8. Does the patient have an artificial prosthesis? Yes No Location: _____

Has the patient received medical treatment from an Allergist, or Ears, Nose and Throat Specialist (ENT)?
Yes No If YES When: _____ Physician: _____

Nasal Surgery: _____ Tonsils removed: _____ Adenoids removed: _____

DENTAL HISTORY (Circle as Needed)

Does the patient have pain and/or clicking in jaw joint? Yes No Side? R L
Have any teeth been injured due to accidents or blows to the mouth? Yes No
Has the patient received or been requested to receive speech correction? Yes No
At what age did the patient's first baby tooth…. Erupt? (months) _____ Fall out? (years) _____
Does the patient require antibiotic pre-medication prior to dental procedures? Yes No
Is the patient aware or concerned about an over or under developed jaw? Yes No

The following habits are of interest:

Thumb/ Finger Sucking	Y	N	Until Age _____	Grinding/ Clenching of teeth	Y	N
Pacifier	Y	N	Until Age _____	Tongue Thrusting	Y	N
Lip-Biting/Sucking	Y	N	Until Age _____	Other Habits? (Please list) _____		

Has the patient had any unusual dental experiences? Yes No
If YES, please explain: _____

Has the patient had a previous Orthodontic Consultation? Yes No Treatment? Yes No
If YES, Date: _____ Dr's Name: _____

Orthodontic Consultation prompted by: Patient Dentist Mother Father Spouse
Sibling Physician Friend Other (specify): _____

What is the primary problem/ concern? _____

Patient's interest in orthodontic treatment:
Wants Treatment Treatment If Necessary Unwilling But Agrees Uncooperative

What is expected from orthodontic treatment? _____

(Next Page)

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of individual completing this form (Must be at least 18 yrs. of age): _____

Relationship to patient: _____ Today's Date: _____

Do not fill out below this line:

Dr's. Initials: _____ Date: _____

Pre-Medication Necessary: Yes No

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

Signed: _____ Date Signed: _____
(Patient)
Signed: _____ Date Signed: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

Signed: _____ Date Signed: _____
(Patient)
Signed: _____ Date Signed: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

Signed: _____ Date Signed: _____
(Patient)
Signed: _____ Date Signed: _____
(Dental Staff Member)