

Elham Amini D.D.S P.C
General Reconstructive Dentistry
Specialist in Orthodontics:
Phu T Le D.D.S

Patient's Personal History:

Patients Name: _____ Birthday: _____

Address: _____ Age: _____ Sex: M F

City, State, Zip: _____ Home Phone: _____

Social Security #: _____ Work Phone: _____

Email: _____

Employer/School: _____ Grade: _____

Spouse's or Father's Name: _____ Employer: _____

Occupation: _____ Home Phone: _____

Mother's Name: _____ Employer: _____

Occupation: _____ Home Phone: _____

Patient's or Parent's Marital Status: Married Single Separated Divorced Other

Family Dentist: _____ Office Phone: _____

Address: _____

Family Physician: _____ Office Phone: _____

Address: _____

Hobbies/Intrests: _____

Contact Sports: Yes No Which Sports: _____

Musical Instruments: Yes No Type: _____ Years Played: _____

Most Convenient Appointment Time: _____

Reason for visiting the Orthodontist: _____

How did you hear about our office: _____

Whom do we have to thank for the referral: _____

Relatives or friends under treatment at this office: _____

Responsible Party

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____ SSN: _____

Primary Dental Insurance

Insured's Name: _____ Relationship to Patient: _____

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____

Orthodontic Coverage: Yes No SSN: _____

Additional Insurance

Insured's Name: _____ Relationship to Patient: _____

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____

Orthodontic Coverage: Yes No SSN: _____

Patients Medical Health History

Is patient currently under a doctor's care: Yes No If so, for what reason: _____

Doctor's Name: _____

Address: _____

Is Patient taking any Medication: Yes No If so, please list: _____

Is Patient pregnant: Yes No

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

If so, Date: _____ Doctor: _____ Reason: _____

Describe any other medical Problems: _____

Has the Patient ever had any of the following: (Check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Allergies to Medicine | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Special Diet | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Recent Weight loss | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Allergies to Anesthetic | <input type="checkbox"/> Immunosuppressive Disorder | <input type="checkbox"/> Other: _____ | |

Has Patient had possible exposure to individuals with:

TB: Yes No AIDS: Yes No Hepatitis: Yes No

Any other contagious Disease: _____

Operations: Transfusions: Yes No

Other Operations: _____

Bleeding From Wounds: Normal Excessive

Respiratory History:

Tonsil Removal: Yes No Adenoids: Yes No Breathing: Nose Mouth Both

Allergies: Hay Fever Yes No Dental Materials Yes No Drugs Yes No

If yes please list drug allergies: _____

Has patient received medical treatment from an ear, nose, and throat specialist: Yes No

If yes, Date: _____ Doctor: _____ Condition: _____

Growth and Development:

Patient's Height: _____ Weight: _____ Father's Height: _____ Mother's Height: _____

Recent rapid growth: Yes No Recent decline in growth: Yes No

Has patient reached puberty: Yes No Menstruation: Yes No Voice Change: Yes No

Hair Growth: Yes No

Please add anything else you feel is important for us to know regarding the patients medical health history: _____

Patients Dental History

When was the patient's last dental visit: _____ Last dental cleaning: _____

Does the patient experience bleeding gums: Yes No

How many times daily does the patient brush: _____

Has the patient had previous dental extractions: Baby teeth Adult Teeth None

Is the patient susceptible to gagging reflex: Yes No

Has the patient ever had serious problems associated with previous dental treatment: Yes No If so, please explain _____

Has the patient experienced injury to :

Head: Yes No Neck : Yes No Face: Yes No Teeth: Yes No

Brief description: _____

Does the patient experience:

Jaw point problems: Yes No

Jaw becoming "stuck", "locked", or "going out": Yes No

Frequent Headaches: Yes No

Pain in/around the ears, temples, or cheeks: Yes No

Tired Jaws: Yes No

Uncomfortable/Unusual Bite: Yes No

Facial Pain: Yes No

Clenching/Grinding of teeth: Yes No

Chewing Difficulties: Yes No

Noises in the jaw joints: Yes No

Difficulty or pain when opening the mouth: Yes No

Has the patient experienced any of the following habits:

Lib biting or sucking: Yes No

Tongue Thrusting: Yes No

Thumb or finger sucking: Yes No

When Stopped: _____

Has the patient received or been requested to receive speech therapy: Yes No

Orthodontic History:

Orthodontic Consultation prompted by: Parent Dentist Other

Has the patient had a previous consultation: Yes No and/or Treatment: Yes No

If so, date: _____ Doctor: _____

Have other family members had orthodontic treatment: Yes No

Patient's interest in receiving orthodontic treatment: Wants treatment Unwilling but agrees if needed Uncooperative

Any Concerns with having Braces: _____

Expectations from treatment: _____

Please add anything you feel is important for us to know regarding the patient's dental health history: _____

Signed: _____

Date: _____

Printed Name: _____

Relationship to Patient: _____