Benkovich Orthodontics

Patient Information & Health History - CONFIDENTIAL

Date

Patient's name_____

Address _____

Home Phone__Cell Phone_____ Birthdate: _SS #_____

E-Mail Address _____

If patient is a minor, give parent's or guardian's name _____

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

Financial Responsible Party Information

Primary Responsible Party Name _____
Last First Middle

Address _____
Street City Zip

Cell phone _____ Birthdate_____ Relationship to Patient _____

Secondary Responsible Party Name_____
Last First Middle

Address _____
Street City Zip

Cell phone _____ Birthdate_____ Relationship to Patient _____

Dental Insurance Information

Policy Holder's Full Name: _____ Policy Holder's Social Security # _____ Policy Holder's DOB: _____

Insurance Company: _____ Employer: _____ Member ID #:_____ Group #: _____

Insurance Co. Address:_____ Insurance Phone No: _____

Do you have dual coverage? Yes_____ No_____ If yes:

Policy Holder's Full Name: _____ Policy Holder's Social Security # _____ Employer: _____

Policy Holder's DOB: _____ Insurance Company: _____ Member ID #:_____ Group #:_____

Insurance Co. Address:_____ Insurance Phone No: _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone_____

Dentist Information

Patient's Dentist: _____ Address, City, State: _____

Last Seen: _____ Reason: _____ Next Appointment: _____

Other dentists/dental specialists being seen: Name: _____ City, State: _____

Reason: _____

JohnDoe

MEDICAL HISTORY

Physician _____Date of Last Visit _____
Address _____Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day?_____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches?_____
Yes No Have you ever experienced chronic ringing in your ears?_____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____

Female Patients only:
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Benkovich to perform a complete orthodontic evaluation.

Signature: _____ Date: _____