AbrahamOrthodontics

Dr. Maxwell Abraham DDS MS FRCD(C)
Specialist in Orthodontics & Dentofacial Orthopedics

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ADULT PATIENT INFORMATION

Fill, Print and Bring in OR Email to: info@orthodontics.com

Date

Patient's name _____ _____ _____
Last First Middle

Residence _____ _____ _____
Street City Postal Code

Mailing Address _____ _____ _____
Street City Postal Code

Birthdate

Home phone Work phone

Cell Phone Email:

Preferred method of contact and consent of use:

Marital Status: Single☐ Married☐ Widowed☐ Separated☐ Divorced☐

Employer Occupation No. years employed

Spouse's Name Relationship to Patient

Employer Occupation No. years employed

Phone

Whom may we thank for referring you to our office?

DENTAL INSURANCE INFORMATION

Insured's Name

Insurance Company Group No. Local No.

Insurance Co. Address Phone No

Do you have dual coverage? Yes☐ No☐ If yes:

Insured's Name

Insurance Company Group No. Local No.

Insurance Co. Address Phone No.

EMERGENCY INFORMATION

Name of nearest relative not living with you

Complete address _____ _____ _____
Street City Postal

Phone

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please Fill ☐ Yes or ☐ No (If Yes, please fill in details)

☐ Yes ☐ No Are you taking any medication?_____
☐ Yes ☐ No Are you allergic to anything? Ie. Medications, latex, nickel_____
☐ Yes ☐ No Do you have a history of a major illness?_____
☐ Yes ☐ No Have you had any operations?_____
☐ Yes ☐ No Have you ever been involved in a serious accident?_____
☐ Yes ☐ No Have you ever smoked or chewed tobacco?_____
☐ Yes ☐ No Have seen a physician in the last 12 months? Why?_____

Female Patients only:

☐ Yes ☐ No Has menstruation started?_____
☐ Yes ☐ No Is the patient pregnant? _____

Fill 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

General Dentist _____ Date of last visit _____

What concerns you most about your teeth, smile or face?

☐ Yes ☐ No Are you presently in any dental pain?_____
☐ Yes ☐ No Are you currently undergoing active dental treatment?_____
☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry?_____
☐ Yes ☐ No Have your wisdom teeth been removed?_____
☐ 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? Where?_____
☐ 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 Is there history of any sleep disturbances? Sleep apnea, snoring?_____

☐ Yes ☐ No Have you ever seen an orthodontist? If yes, who and when?_____
☐ Yes ☐ No What is your attitude toward receiving orthodontic treatment?_____
☐ Yes ☐ No Is there anything you would change about your face?_____
☐ Yes ☐ No Has anyone in your family received orthodontic treatment?_____
How did they feel about the result?_____

☐ 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 Are you aware that some appointments will be during work hours?_____

To evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:
Do you feel that your teeth are

Too small or short?	☐No	☐Yes
Too large or long?	☐No	☐Yes
Crooked or crowded?	☐No	☐Yes
Misshaped (uneven/pointed)?	☐No	☐Yes
Off color?	☐No	☐Yes

Do you feel your front teeth "stick out too much" ("buck teeth")?
☐No ☐Yes
Do you want to improve any other features about your face (nose, chin, wrinkles, etc?)
☐No ☐Yes_____
Are there spaces between your teeth that you do not like?
☐No ☐Yes
Does too much or too little gum tissue show when you smile?
☐No ☐Yes
What kind of treatment interests the patient?:
☐ Metal braces ☐ Clear braces ☐ Clear removable retainers (Invisalign, etc)

Are there other dental issues not listed above that you would like to discuss or have treated?
_____

BENEFITS & ACKNOWLEDGEMENT

Benefits of Orthodontics: Esthetics, 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.

Acknowledgement: I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I authorize Dr. Maxwell Abraham to perform a complete orthodontic evaluation with diagnostic imaging (when necessary) and authorize use and disclosure of this information as per the office privacy agreement. I understand that this information is collected to provide me and my family with safe and efficient care. I also understand that this office endeavors to ensure that personal information is accurate, up to date and protected. It is your responsibility to inform us of any changes in your Medical status.

Patient Signature: _____ Date:

Doctor Signature: _____ Date:

_____
Reviewed by: Dr. Maxwell Abraham DDS MS FRCD(C)

SEND EMAIL **PRINT**

If prompted, please email to info@orthodontics.com