AbrahamOrthodontics

Dr. Maxwell Abraham DDS MS FRCD(C)

Specialist in Orthodontics & Dentofacial Orthopedics
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PATIENT INFORMATION IF UNDER 18

Fill, Print and Bring into your visit OR Email to: info@orthodontics.com

Date

Patient's name (Last / First / Middle)

Address (Street / City / Postal Code)

Nickname Birthdate Social Security#

School Sports/Hobbies

Parent or guardian name

Whom may we thank for referring you to our office?

RESPONSIBLE PARTY INFORMATION

Name (Last / First / Middle)

Residence (Street / City / Postal Code)

Home phone Work phone

Cell/other phone Email address

Preferred method of contact and consent of use:

Birthdate Relationship to Patient

Employer Occupation # Yrs employed

Spouse's Name Relationship to Patient

Birthdate Same Responsibility as above? Yes☐ No☐

Employer Occupation Work Phone # Yrs employed

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

Complete address

Street | City | Postal Code | Phone Number

MEDICAL HISTORY

Physician | Date of Last Visit

Address | Phone

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

☐ Yes ☐ No Is the patient taking any medication?_____
☐ Yes ☐ No Is the patient allergic to anything? ie. Medications, latex, nickel? _____
☐ Yes ☐ No History of a major illness? _____
☐ Yes ☐ No Has the patient had any operations? _____
☐ Yes ☐ No Ever been involved in a serious accident? _____
☐ Yes ☐ No Have seen a physician in the last 12 months? _____Why? _____

For Growth Evaluation (18 & Under)

Height of parents? Mom_____ Dad_____
☐ Yes ☐ No Has the patient reached puberty? _____
Name and Ages of siblings? _____
Female Patients only:
☐ Yes ☐ No Has menstruation started? _____
☐ Yes ☐ No Is the patient pregnant? _____

Fill in any of the medical conditions below that the patient has had or currently has.

☐ 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 or the patient most about their smile?

☐ Yes ☐ No Is there currently dental pain, disease (cavities, etc) or active dental treatment _____
☐ Yes ☐ No Do gums bleed when brushing? _____
☐ Yes ☐ No Ever experienced any unfavorable reaction to dentistry? _____
☐ Yes ☐ No Has the patient ever lost or chipped any teeth? _____
☐ Yes ☐ No Have there been any injuries to face, mouth, or teeth? _____
☐ Yes ☐ No Is the patient aware of delayed, missing or extra teeth? _____
☐ Yes ☐ No History of dental extractions? _____

☐ Yes ☐ No Any type of thumb or tongue habit? If stopped, when? _____
☐ Yes ☐ No Mouth breathing (day or night)? _____
☐ Yes ☐ No Is there history of adenoid or tonsil pathology? _____
☐ Yes ☐ No Is there a history of sleep disorders or disturbances (ie. Sleep apnea, snoring?) _____

☐ Yes ☐ No Has the patient ever seen an orthodontist? If yes, who and when? _____
☐ Yes ☐ No What is the patient's attitude toward receiving orthodontic treatment? _____
☐ Yes ☐ No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____

☐ Yes ☐ No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
☐ Yes ☐ No Experience jaw clicking or popping? _____

☐ Yes ☐ No Aware of clenching or grinding teeth during the day? _____
☐ Yes ☐ No Experience “tension” headaches? _____
☐ Yes ☐ No Has the patient ever experienced chronic ringing in the ears? _____
☐ Yes ☐ No Does the patient need extra help with instructions? _____
☐ Yes ☐ No Has the patient had any negative experience in a dental office? When? _____

☐ Yes ☐ No Is the patient sensitive or self-conscious about his/her teeth, facial features? _____
☐ Yes ☐ No Are you aware that some appointments will be during school/work hours? _____
☐ Yes ☐ No Are you interested in treatment for yourself? _____

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
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:
By agreeing and sending 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 child’s medical status.
If / when a minor patient turns 18 during the course of treatment, we will continue to discuss treatment details with the responsible party *unless* we are notified otherwise by the patient in writing. We review and sign this document with you. Please submit upon completion.
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Consent:

Responsible Party Signature: _____ Date:

Patient: _____ Date:

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

SEND EMAIL **PRINT**

If prompted, send to info@orthodontics.com