associates in ORTHODONTICS
Librizzi, Blasius, & Librizzi

Name of Person Completing Form: Relationship to Patient:

Patient Info

DOB: _____ Age: ____ Sex: Male / Female

Patient's Name: (First) _____ (MI) _____ (Last) _____

Patient's Address: _____

City _____ State _____ Zip _____

Home #: _____ Cell#: _____

General Dentist: _____ Last Visit: _____

Whom may we thank for referring you? _____

Other Family members seen by us: _____

Parent/Responsible Party #1

Name:_____ Relationship to Patient: _____

Address: _____ City_____ State _____ Zip_____

Home#: _____ Cell#: _____ Work#: _____

Email: _____

Spouse Name: _____ Relationship to Patient: _____

Home#: _____ Cell#: _____ Work#: _____

Parent/Responsible Party #2 (if applicable)

Name:_____ Relationship to Patient: _____

Address: _____ City_____ State _____ Zip_____

Home#: _____ Cell#: _____ Work#: _____

Email: _____

Spouse Name: _____ Relationship to Patient: _____

Home#: _____ Cell#: _____ Work#: _____

Primary Insurance (Dental)

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SS#: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Insurance Company: _____ Policy ID: _____ Group #: _____

Insurance Company Address: _____ Insurance Phone #: _____

Secondary Insurance (if applicable)

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's SS#: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Insurance Company: _____ Policy ID: _____ Group #: _____

Insurance Company Address: _____ Insurance Phone #: _____

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General Information (if patient is child)

Hobbies

Brothers/Sisters (include ages)

Medical History

Medical Physician_____Phone_____Last Visit_____

Is patient currently under the care of a physician? Yes___ No____ If Yes, explain_____

Is the patient currently taking medications? Yes___ Medication: _____

Has puberty begun? (child) Yes____ No____ Is the patient pregnant? Yes____ No_____

Is the patient allergic to any of the following?

___Aspirin
___Codeine
___Tetracycline
___Metals/Plastics
___Erythromycin
___Penicillin
___Sulfa
___Latex

Other Allergies/Sensitivities:
_____

Check any that apply:

__ Heart problems
__ Chronic Disease
__ Hospitalization/Operation
__ Breathing Problems
__ Speech Problems
__ Learning Disabilities
__ Recurring Headaches
__ Tonsillectomy / Adenoidectomy
__ Use of tobacco products
__ Other medical conditions
Explain:_____
_____

Dental History

Has the patient ever been evaluated for orthodontic treatment? Yes___ No____

Previous Ortho Treatment? Yes___ No___ If yes, Where/With Whom?_____

Patient history of:	Please circle		
Habits?	Yes	No	Clenching/Grinding____ Thumb/Finger Sucking____ Tongue thrusting____ Mouth Breather____ Nail Biting____
Missing or Extra teeth?	Yes	No	Describe:_____
Tooth Injury?	Yes	No	Describe:_____
Teeth Extracted?	Yes	No	Which teeth?_____
Periodontal (Gum) Treatment?	Yes	No	Where:_____
Oral Surgery	Yes	No	Describe:_____
Jaw Joint Discomfort (TMJ/TMD)	Yes	No	Describe:_____

Have you ever experienced an unfavorable reaction to dentistry? If so, Explain: _____

I hereby certify that I have reviewed the above history and that it is accurate to my knowledge at this time. If there are future changes in this information, I will inform this practice of these changes immediately. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

_____ _____

(Signature of person giving history information) Date

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