Welcome to the Orthodontist

We would like to welcome you to Dr. Deborah Himelhoch's office. We provide professional service in a comfortable, friendly environment. The benefits of a happy, functional smile are immeasurable. Together we will achieve your orthodontic goals!

1. Tell us about yourself:

Today's date: _____

Name: _____
Last First MI Mr. Mrs. Ms.

_____Male _____Female Date of Birth: _____/_____/_____ Age: _____

Home Address: _____
Street Apt/Condo #

_____
City State Zip Code

E-mail address: _____ Phone #:_____

Employer: _____ Work phone: _____

Marital Status: ___Single ___Married ___ Partnered ___ Separated ___Divorced

Whom should we contact in the event of an emergency:_____
Name Phone Relationship

2. Spousal information (if applicable)

Name:_____ Date of Birth: ___/____/____ Phone #:_____

Employer:_____ Work phone number:_____

Other family members seen by us: _____

Whom may we thank for referring you or how did you hear about our office?_____ ___

3. Your Dental History

What are your main orthodontic concerns that bring you here today? _____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult issue associated with previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced discomfort in your jaw (TMJ/TMD) ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Who is your current dentist? : _____

Do you like your smile? ☐ Yes ☐ No

Are you missing any permanent teeth? ☐ Yes ☐ No

Have you ever had an injury to your: Teeth Mouth Chin (please circle)

Do you have any speech problems? ☐ Yes ☐ No

4. Your Medical History

Physician: _____ Phone: _____ Date of Last Visit:_____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please describe your physical health: ☐ Good ☐ Fair ☐ Poor

Are you allergic to: Latex? ☐ Yes ☐ No Metal/Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

Please list ALL allergies you have (drugs, food, materials, etc…): _____
_____

Please list ALL medications you are currently taking: _____
_____

FOR WOMEN: Are you pregnant: ☐ Yes ☐ No

Are you nursing: ☐ Yes ☐ No

Have you ever had any of the following medical problems? (Please circle Y for yes or N for no)

Y N Abnormal Bleeding/Anemia	**Y N Drug/Alcohol Abuse**	**Y N Fever Blisters/Herpes**
Y N Artificial Bones/Joints/Valves	**Y N Anxiety/Depression Disorder**	**Y N Heart Murmur/Heart Attack/Stroke**
Y N Asthma/Arthritis	**Y N Congenital Heart Defect**	**Y N Hemophilia**
Y N Blood Transfusion	**Y N Seizures/ Epilepsy**	**Y N HIV+/ AIDS**
Y N Cancer/Chemotherapy	**Y N Glaucoma**	**Y N Kidney/Liver problems**
Y N Diabetes	**Y N Handicaps/Disabilities**	**Y N Rheumatic/Scarlet Fever**
Y N Difficulty Breathing/Emphysema	**Y N Heart Surgery/Pace Maker**	**Y N Sickle Cell Disease/Traits**
Y N Hepatitis	**Y N High/Low Blood Pressure**	**Y N Tuberculosis (TB)**
Y N Mitral Valve Prolapse	**Y N Radiation**	**Y N Severe/Frequent Headaches**
Y N Shingles	**Y N Sinus Problems**	**Y N Ulcers/Colitis**

Please discuss any serious medical problems you have had:

_____

_____

I agree that the information given above is accurate to the best of my knowledge. I understand that it is my responsibility to inform Dr. Deborah Himelhoch's office of any changes in my dental or medical history. I authorize the dental staff to perform necessary dental services I may need.

_____

Signature Date

For Dentist's Use Only *For Dentist's Use Only* ***For Dentist's Use Only***

I verbally reviewed the medical/dental information above with the patient named herein.
Initials: _____ Date: _____

Comments: _____

_____

_____