

DR1: \_\_\_\_\_



**PATERNO ORTHODONTICS, LLC**  
Michele C. Paterno, D.M.D., M.S.D.  
Orthodontics for Children and Adults

TX Breakdown: \_\_\_\_\_

**CHILD PATIENT INFORMATION**

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Nickname \_\_\_\_\_ Birthdate \_\_\_\_\_ Male / Female \_\_\_\_\_

School \_\_\_\_\_ Sports/Hobbies \_\_\_\_\_

Names and ages of other children in the family \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Parent/Guardian \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Member ID No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Member ID No. \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

DR1: \_\_\_\_\_



**PATERNO ORTHODONTICS, LLC**  
**Michele C. Paterno, D.M.D, M.S.D.**  
**Orthodontics for Children and Adults**

TX Breakdown: \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

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

- Yes No Is the patient taking any medication? \_\_\_\_\_
- Yes No Is the patient allergic to any medication? \_\_\_\_\_
- 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? \_\_\_\_\_
- Female Patients only:
- Yes No Has menstruation started? \_\_\_\_\_
- Yes No Is the patient pregnant? \_\_\_\_\_

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

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

Are there any medical conditions or diagnoses we have not discussed that you are aware of? \_\_\_\_\_  
\_\_\_\_\_

**DENTAL HISTORY**

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Reason for consultation today? \_\_\_\_\_

- Yes No Is the patient presently in any dental pain? \_\_\_\_\_
- 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 Any musical instruments played? List: \_\_\_\_\_
- Yes No Do gums bleed when brushing? \_\_\_\_\_
- Yes No Any type of thumb/finger sucking or tongue habit? \_\_\_\_\_
- Yes No Is the patient a mouth breather? \_\_\_\_\_
- Yes No Has the patient ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- 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 Is the patient sensitive or self-conscious about his/her teeth? \_\_\_\_\_

**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 also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Michele C. Paterno to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_