



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

ADULT PATIENT INFORMATION

Date _____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone _____ Cell Phone _____

Email _____ Birthdate _____ Social Security # _____

Marital Status: Single__ Married__ Widowed__ Separated__ Divorced__

Employer _____ Occupation _____

Spouse's Name _____

Employer _____ Occupation _____

Social Security # _____ Birthdate _____ Work Phone _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Member ID No. _____

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

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Member ID No. _____

EMERGENCY INFORMATION

Name: _____

Complete address: _____
Street City Zip

Phone: _____

Relationship to Patient _____

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

Signature _____

Date _____



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MEDICAL HISTORY

Physician _____

Address _____

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

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- 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 Are you 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 Are you presently in any dental pain? _____
- 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? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb/finger or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- 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? _____

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: _____