Patient Information

Patient's Name: _____
First Middle Last Nickname

Address: _____
Street City State Zip Code

Home Phone: _____ Cell: _____ Work: _____

Birthday: _____ Age: _____ Gender: _____

Who is your General Dentist? _____

Who can we thank for your referral? _____

Responsible Party Information

Name: _____
First Middle Last

Relationship to Patient: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

How would you prefer to be contacted for appointment reminders: Text, Email or Both _____

Name: _____
First Middle Last

Relationship to Patient: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

How would you prefer to be contacted for appointment reminders: Text, Email or Both _____

Dental Insurance Information

Insured's Name: _____ Relationship to Patient: _____

Employer : _____ SS or ID #: _____ Birthdate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insured's Name: _____ Relationship to Patient: _____

Employer: _____ SS or ID #:- _____ Birthdate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Dental History

When was you last dental checkup/ cleaning? _____

Have you ever had a negative dental experience? _____

Do you have any missing, extra, or impacted teeth? _____

Have you ever visited with an orthodontist before? _____

Do you feel that your teeth are too small or short? Y N

Do you feel that your teeth are too large or long? Y N

Do you feel that your teeth are misshapen? Y N

Do you feel that your teeth are too crooked or crowded? Y N

Do you feel there is too much or too little gum tissue showing when you smile? Y N

Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)? Y N

Do you have any speech problems? Y N

Airway History

Have you ever worn a CPAP Device? Y N

Do you snore at night? Y N

Are you a mouth breather? Y N

Do you clench/grind your teeth? Y N

Are you a restless sleeper? Y N

Do you sleep walk? Y N

Any issues with bed wetting? Y N

Do you sleep talk? Y N

Have you ever worn an Oral Appliance for sleeping or snoring? Y N

Do you have problem concentrating either at home, school or work? Y N

Have your tonsils or adenoids been removed? Y N

Habits

Sucking your thumb or fingers Y N

Thrusting your tongue when swallowing Y N

Lip sucking or biting Y N

Other oral/mouth habits Y N

Medical History

Have you ever had any of the following medical problems listed below?

Artificial joints	Y N	Fever blisters/Cold Sores	Y N
Arthritis	Y N	Hearing impairment	Y N
Asthma	Y N	Heart problems	Y N
Bleeding disorder	Y N	Hepatitis	Y N
Blood pressure problems	Y N	HIV+/AIDS	Y N
Chemo/Radiation	Y N	Kidney/Liver defects	Y N
Chicken pox	Y N	Mitral valve prolapse	Y N
Convulsions/Epilepsy	Y N	Sinus problems	Y N
Diabetes	Y N	Back/Neck problems	Y N

Are you currently taking any medications? If yes please provide a complete list and dosage: _____

_____

Have you ever taken bisphosphonate drugs used to treat osteoporosis or multiple myeloma? Y N

Have you ever taken medications to strengthen your bones and prevent fractures? Y N

Has puberty begun? Y N

Has menstruation (period) begun? Y N NA

Are you pregnant? Y N If yes, week #? _____

Do you have any allergies to the following?

Aspirin	Y N	Latex	Y N
Any metals	Y N	Penicillin	Y N
Codeine	Y N	Tetracycline	Y N
Dental Anesthetics	Y N	Erythromycin	Y N

Other allergies not listed: _____

Please elaborate on any other dental or medical concerns: _____

_____

Do you have any questions for Dr. Matt Gaworski? _____

_____

Signature (Parent/Guardian if minor): _____ Date: _____

Reviewed by Dr. Matt Gaworski: _____ Date: _____