BEFORE FILLING OUT, YOU MUST: *Computer Users: Download PDF & Open in Acrobat **Mobile Users: 1. Download Adobe Acrobat Reader app. 2. Import to Acrobat 3. Fill & Sign

Today's Date: ____________________

Patient Name: __________________________________ Nickname: ____________________

Maiden Name if Applicable: _________________________________

Date of Birth: ________________________ Age: _____ Gender: __________________

Name of your physician: _____________________________ Office Phone: _____________________

Physician's Address: __________________________________ Date of last exam: __________________

Are you in good health .... Yes ____ No ____ Do not know _____

Do you have a health problem .... Yes ____ No ____ Do not know _____

If yes, explain: ____

Have you ever been hospitalized, had general anesthesia, or emergency room Visits .... Yes ____ No ____ Do not know _____

Are your immunizations up to date? .... Yes ____ No ____ Do not know _____

Do you have allergies to medications (drugs), medical products (latex), or the environment (dust, mites, pollen, mold) .... Yes ____ No ____ Do not know _____

List past medications taken: ____

List daily medications you are now taking: ____

Have you ever had or been treated by a physician for:

Check one for each condition

Yes	No	?			Yes	No	?	
			a. Problems at birth					p. Cancer
			b. Heart murmur					q. Cerebral Palsy
			c. Heart disease					r. Seizures
			d. Rheumatic fever					s. Asthma
			e. Anemia					t. Cleft lip/palate
			f. Sickle Cell anemia					u. Speech or hearing problems
			g. Bleeding/hemophilia					v. Eye problems/contact lenses
			h. Blood transfusion					w. Skin problems
			i. Hepatitis					x. Tonsil/adenoid/sinus problems
			j. AIDS or HIV+					y. Sleep problems
			k. Tuberculosis					z. Emotional/behavior problems
			l. Liver disease					aa. Radiation therapy
			m. Kidney disease					bb. Growth problems
			n. Diabetes					cc. Attention deficit disorders
			o. Arthritis					

What is your main concern about your dental condition? ______________________________________

Have you been to a dentist before? No ____ Yes ____ If yes, date of last visit: _______________

Regular dentist's name: ____

Check one for each condition:

Yes	No	?	
			a. Have you ever had dental x-rays? Date of last x-rays? ______________________________
			b. Will you be uncooperative? If yes, explain: _______________________________________
			c. Have you experienced any complications following dental treatment? If yes, explain: ____
			d. Have you had cavities and/or toothaches?
			e. Are your teeth sensitive to temperature or food?
			f. Did you ever get instructions in brushing?
			g. Do your gums bleed when brushed?
			h. Do you use fluoride products: rinses, drops, tabs?
			i. Do you or have you had any clicking or pain in the jaw joint?
			j. Do or have you had any problems opening or closing their mouth?
			k. Have you inherited any family facial or dental characteristics? If yes, explain: ____

			l. Have you ever injured your teeth?
			m. Have you ever injured your jaws or face?
			n. Does or did you use a pacifier as a child?
			o. Does or did you suck your fingers or thumb as a child?

Demographic Information

Your Residence Address: ____

City: _______________________________ State: _________ Zip: __________________________

Your Mailing Address (if different): ____

City: __________________________________ State: _________ Zip: _______________________

Your Telephone: Residence: __________________ Cell: ___________________Work: ______________

Your E-Mail Address: ____

Your Employer: _______________________ Occupation: _____________ No. Years Employed: ______

Spouse's Name: ___________________________ Maiden Name (if Applicable): ___________________

Souse's Birth Date: _________________________ Gender: ________________

Spouse's Telephone: Cell: ____________________Work: __________________

Spouse's E-mail Address: ____

Spouse's employer: ____________________Occupation: ______________ No. Years Employed: ______

Dental Insurance Information

Name of Your Dental Insurance: ____

Member ID # or Soc. Sec. #: ______________________________ Group#: ______________________

Insurance Co. Address: ____

Insurance Co. Phone #: ________________________

Name of Spouse's Dental Insurance: ____

Member ID # of Soc. Sec. #: _______________________________Group#: ____________________

Insurance Co. Address: ____

Insurance Co. Phone #: ________________________

Do you have any other dental problems we should know about? __________ Please explain: ________

____

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

Person completing this form: Signature ____

Relationship to patient: __________________________

Click SUBMIT button to send your completed form to our office. This button only works in Acrobat.

If you are having trouble, you can send the form in an email to: fc1@byrneorthodontics.com