ORTHODONTICS

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Orthodontics, Oral Facial Orthopedics
for Adults and Children

Welcome to our office! Your first visit to our office will be for the purpose of a thorough examination and the Doctor's opinion as to whether treatment is indicated. If it appears that treatment is needed at this time, full diagnostic records may be requested by the Doctor. There is no fee for this initial evaluation by Dr. Kubik.

Please fill in the following:

Patient's name _____ Birthdate _____
Month/Day/Year

Home Address _____ Sex M ☐ F ☐
No. Street

City _____ Zip _____ Home phone _____

Previous address _____
No. Street City State

Employed by _____ Occupation _____

Business address _____ Business phone _____

Spouse's name _____ Occupation _____

Employed by _____ Business phone _____

Business address _____

Person responsible for this account _____

Social Security number of person responsible for this account _____

Have you had previous orthodontic treatment? _____ If so, by whom _____

Referred by _____ Family dentist _____

Address _____

Are you covered by insurance for orthodontic treatment? Yes ☐ No ☐

If so, give name of company and policy no. _____

_____ _____
Date Signature

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ADULT

Medical History

Name of physician_____ City_____ Phone_____

Do you have a current medical problem? Yes ☐ No ☐ What _____

Have you ever had any of the following:

- ☐ Nervous breakdown, psychotherapy
- ☐ Lung trouble (TB, asthma, emphysema)
- ☐ Hepatitis, liver disease, jaundice
- ☐ Arthritis, sore joints
- ☐ Diabetes
- ☐ Excessive bleeding
- ☐ Blood trouble, anemia, leukemia
- ☐ VD (syphilis, gonorrhea)
- ☐ X-ray, indium, cobalt treatments
- ☐ Shortness of breath
- ☐ Swelling of ankles or feet
- ☐ Pain, pressure or tightness in chest
- ☐ Heart attack
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Fainting spells, convulsions, epilepsy
- ☐ Headaches when lying down

Are you now:

- ☐ Pregnant
- ☐ On a prescribed diet
- ☐ Using Thyroids
- ☐ Using hormones (including birth control)
- ☐ Using anticoagulents
- ☐ Using Dilantin
- ☐ Using other medicines (please specify)

_____

Are you now taking or using medicines for:

- ☐ Diabetes (pills or shots)
- ☐ Nerves (tranquilizers)
- ☐ Sleeping
- ☐ Heart or blood pressure (digitalis, nitroglycerin, resorpin)
- ☐ Blood (liver, iron pills)
- ☐ Stomach trouble (ulcer, other)
- ☐ Headaches
- ☐ Arthritis or rheumatism
- ☐ Allergy

Have you ever been sick from, shown an allergy to, or told not to take:

- ☐ Antibiotics
- ☐ Codeine
- ☐ Aspirin
- ☐ Novocaine (or other dental anesthetic)
- ☐ Other drugs or medicines (please specify)

_____

Have you ever had a tumor or cancer? Yes ☐ No ☐ Where? _____

Have you ever had a major operation? Yes ☐ No ☐ What kind? _____

Have you ever been involved in a serious accident? Yes ☐ No ☐ Describe: _____

Date of last medical exam _____
month year

	Yes	No
Have you come to this office for relief of pain?	☐	☐
If yes, where is the pain? _____		
Have you had the pain more than 3 weeks?	☐	☐
Are you presently having dental pain?	☐	☐

Insurance Information

If you have any type of dental insurance, please complete

Name of insurance company _____

Name of dental plan_____ Group number_____

Employee_____ Employee social security no._____

Patient _____

Relationship to employee_____ Patient's birthdate_____

Employer _____

Employer's Address _____
Street City Area code Phone

Union local no._____ Address_____

Dental History

	Yes	No
Have you had orthodontic treatment?	☐	☐
If Yes, when _____		
Do you have unreplaced missing teeth?	☐	☐
If Yes, why haven't you had them replaced? _____		
Was it ever suggested?	☐	☐
Do you have difficulty swallowing?	☐	☐
Do your gums bleed when brushing your teeth?	☐	☐
Have you ever had professional instructions on dental home care?	☐	☐
Is any part of your mouth sensitive to temperature, or pressure?	☐	☐
If Yes, which part? _____		
Do you have any pain or soreness around the eyes or ears?	☐	☐
Are you dissatisfied with your teeth and their appearance?	☐	☐
Have you ever had a thumb or finger sucking habit?	☐	☐
If Yes, has it been discontinued and when? _____		
Do you breathe predominently through your mouth?	☐	☐
If Yes, why do you feel this occurs? _____		
Have you had a history of frequent ear, nose or throat infections?	☐	☐
Have you had tonsils and/or adenoids removed?	☐	☐

Occlusal Screening

Do you clench or grind your teeth during the day?	☐	☐
Have you been made aware of clenching or grinding your teeth during the night?	☐	☐
Do you have chronic headaches, or neck and shoulder pains?	☐	☐
Do you ever wake up with an awareness of, or about, your teeth or jaw like you've had them clenched in your sleep?	☐	☐
Do you have any awareness in the muscles of your neck or shoulders?	☐	☐
Do you have a tight or stiff neck?	☐	☐
Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)?	☐	☐
Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?	☐	☐

Which side do you chew on? R ☐ L ☐ Both ☐

Do you notice any of the following:

Ringing in the ears _____ Pain in teeth _____

Neck Pains _____ Face Pains _____

Back Pains _____ Jaw Pains _____

Headaches _____ Grinding of Teeth _____

Popping, clicking or grating sound in the jaw _____

Have you ever been in an accident? _____ When _____

Has there ever been a blow to the jaw? _____ When _____

	Yes	No
Is there a specific orthodontic problem that concerns you?	☐	☐

If Yes, please describe: _____

_____

_____