WELCOME

Welcome to Ricci Orthodontics. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you.

Patient Information

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (SEX) _____ (MARITAL STATUS)

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Nickname _____ Birthdate _____ (MM-DD-YYYY) Email _____ SSN _____ (999-99-9999)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) Ext _____

Employer _____ Occupation _____ # Years Employed _____

General Dentist _____ Last Visited _____

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

Spouse/Additional Contact Information

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (SEX) _____ (MARITAL STATUS)

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone _____ (999-999-9999) Cell Phone _____ (999-999-9999) Work Phone _____ (999-999-9999) Ext _____

Birthdate _____ (MM-DD-YYYY) Email _____ Relationship to Patient _____

Employer _____ Occupation _____ # Years Employed _____

Insurance Information

Policy Owner's Name _____ Policy Owner's SSN _____ (999-99-9999)

Birthdate _____ (MM-DD-YYYY) Relationship to Patient _____

Policy Owner's Employer _____ Address _____

Insurance Company _____ Group No. (plan, local or policy) _____

Insurance Co. Address _____ Phone _____ (999-999-9999)

Secondary Insurance: Policy Owner's Name _____ Policy Owner's SSN _____ (999-99-9999)

Birthdate _____ (MM-DD-YYYY) Relationship to Patient _____

Policy Owner's Employer _____ Address _____

Insurance Company _____ Group No. (plan, local or policy) _____

Insurance Co. Address _____ Phone _____ (999-999-9999)

Medical History

Are you under the care of a physician? ☐ Yes ☐ No If Yes, explain _____

Physician _____ Phone _____ Last visit _____

Address _____

Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____ Do you like your smile? ☐ Yes ☐ No

What are the main concerns you would like orthodontics to correct? _____

Have you ever been evaluated for orthodontic treatment? _____

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? ☐ Yes ☐ No

Have your tonsils or adenoids been removed? ☐ Yes ☐ No Have you ever had an injury to : (select all that apply) ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ☐ Yes ☐ No If Yes, explain _____

Have you ever received gum treatment? ☐ Yes ☐ No If Yes, explain _____

Do your gums bleed? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Have you ever taken drugs to strengthen your bones? ☐ Yes ☐ No If Yes, explain _____

Do you or have you ever had any of the following habits? ☐ Lip sucking ☐ Nail biting ☐ Prolonged bottle / pacifier ☐ Clenching / grinding teeth ☐ Mouth breather ☐ Tongue thrusting ☐ Thumb / finger sucking

Please check Yes or No to the following and give date:

	YES	NO	YEAR
ADD / ADHD	☐	☐	
Anemia	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Blood Disorder	☐	☐	
Bone Disorder	☐	☐	
Breathing Difficulties	☐	☐	
Cancer	☐	☐	
Convulsions	☐	☐	
Diabetes	☐	☐	
Dizziness	☐	☐	
Drug / Alcohol Abuse	☐	☐	
Eating Disorder	☐	☐	
Endocrine Disorder	☐	☐	

	YES	NO	YEAR
Epilepsy	☐	☐	
Eye Disorder	☐	☐	
Glaucoma	☐	☐	
Hearing Disorder	☐	☐	
Heart Attack	☐	☐	
Heart Disorder / Defect	☐	☐	
Heart Murmur	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
HIV+ / AIDS	☐	☐	
Immune System Disorder	☐	☐	
Joint Replacement	☐	☐	
Kidney Disorder	☐	☐	
Liver Disorder	☐	☐	

	YES	NO	YEAR
Lung Disorder	☐	☐	
Mitral Valve Prolapse	☐	☐	
Neurological Disorder	☐	☐	
Psychiatric Disorders	☐	☐	
Radiation Treatment	☐	☐	
Rheumatic / Scarlet Fever	☐	☐	
Seasonal Type Allergies	☐	☐	
Seizures	☐	☐	
Sickle Cell Anemia / Trait	☐	☐	
Stroke	☐	☐	
Surgery / Hospitalization	☐	☐	
Thyroid Disorder	☐	☐	
Tuberculosis	☐	☐	
Ulcers	☐	☐	

Other _____

Please give greater details where necessary _____

Are you allergic to any of the following?

☐ Aspirin ☐ Erythromycin
☐ Codeine ☐ Penicillin
☐ Tetracycline ☐ Latex
☐ Any Metals / Plastics

Other Allergies / Sensitivities:

List all drugs you are currently taking

List any serious medical condition(s) treated

Sleep Apnea Screening / Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

Score:

0 - 10 Normal Range
10 - 12 Borderline
12 - 24 Abnormal

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form _____

Date _____