Eric Ornella DDS MSD

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Patient Information for_____ Birthdate _____
Address_____ Age____ Male_____ Female____
City_____ State_____ Zip code _____Email _____ SS# _____
Home Phone_____ Cell Phone_____ Preferred Contact: Text____ Email ____ Phone ____
School_____ Dentist_____ How did you hear about Dr O? _____
Responsible Party for Account _____ Relationship to Patient _____

Mother _____ SS# _____ **Father** _____SS# _____
Address_____ Address_____
Employer_____ Employer _____
Orthodontic Insurance_____ Orthodontic Insurance _____
Cell Phone _____Provider_____ Cell Phone _____ Provider_____

Has anyone in your family been a patient in our office? If Yes, who? _____
How do you feel about wearing braces or retainers? _____
Have you seen an orthodontist before? If Yes, who? _____
Have you had orthodontic treatment before? If Yes, Explain_____

Dental History

Last Dental Visit _____Have you had any permanent Teeth Removed? If Yes, Explain_____

Please check all that apply and circle to specify details

( ) Any injuries to face, mouth, teeth? ( ) Mouth-breathing - awake or asleep? ( ) Any speech problem?
( ) More than average decay? ( ) Family history of a strong lower jaw? ( ) Is this visit a second opinion?
( ) Any extra permanent teeth? ( ) Any difficulty swallowing or chewing? ( ) Night grinding or clenching?
( ) Do you visit your dentist regularly? ( ) Any pain or clicking on opening mouth ( ) History of lip sucking?
( ) History of thumb sucking? ( ) History of finger sucking?

What would you like orthodontic treatment to accomplish? (Please check all that apply)

( ) Straight Teeth ( ) Stop Harmful Habits ( ) Correct Crossbite ( ) Make Room for Crowded Teeth
( ) A Good Bite ( ) Relieve Pain ( ) Stabilize Mobile Teeth ( ) Reduce Overbite or Underbite
( ) Close Spaces ( ) Stabilize TMJ ( ) A Beautiful Smile ( ) Prevent Future Problems

Medical History

( ) Joint Swelling ( ) Bone Disorders ( ) Heart Trouble ( ) Rheumatic Fever
( ) Thyroid Problems ( ) Diabetes ( ) Hepatitis ( ) Emotional Problems
( ) Brain Injury ( ) Tuberculosis ( ) Anemia ( ) Asthma
( ) Epilepsy ( ) Faintness/Dizziness ( ) Kidney/Liver Disease ( ) Prolonged Bleeding
( ) Tonsillitis ( ) Earaches ( ) Cold Sores/Cankers ( ) Acquired Immune Deficiency
( ) Tonsillectomy ( ) Adenoidectomy

List and describe any other serious medical problems not listed above _____
List any allergies (Penicillin, dental anesthetic, latex…)_____
List current medications _____
Is the patient under the care of a physician? Yes____ No____ Physician _____
Does patient require antibiotic premedication prior to dental procedures? If Yes, Explain _____
Is there anything not mentioned above that should be considered before starting orthodontic treatment? _____
_____

I certify that the above information is accurate. I will inform Dr Ornella of any changes to this information. I authorize the release of information as necessary for dental or medical referral or consultation in compliance with the HIPPA Privacy Act.

Signed_____ **Date**_____

Thank you for the information ▫ Welcome to Our Practice!