Member American Association of Orthodontists

Siomka Orthodontics
Leon V. Siomka, DDS, MS

PATIENT INFORMATION:

Patient's Name: _____ Preferred: _____

Birthdate: _____ Gender: Male ❑ Female ❑ Non binary ❑ Pronoun: _____

Address: _____

City: _____ State: _____ Zip: _____

Appointment Confirmation Cell#: _____ Other # _____

Has any member of your family been treated in our office? ❑ No ❑ Yes _____

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

PARENT/GUARDIAN INFORMATION:

Relationship to patient: _____ Relationship to patient: _____

Name (First/Middle/Last) _____ Name (First/Middle/Last) _____

DOB: _____ DOB: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Cell#: _____ Cell#: _____

Work#: _____ Work#: _____

Email: _____ Email: _____

INSURANCE INFORMATION:

Please notify the office of any insurance changes at each visit that may affect your account. As a courtesy, we will bill your insurance company on your behalf. You are responsible for any remaining balance.

Subscriber: _____ Subscriber: _____

DOB: _____ ID/SSN: _____ DOB: _____ ID/SSN: _____

Primary Insurance Co.: _____ Primary Insurance Co.: _____

Phone#: _____ Phone#: _____

Employer: _____ Employer: _____

EMERGENCY CONTACT Person to contact in case of an emergency other than Parent/Guardian.

Name: _____ Phone#: _____ Alt#: _____

Address/City/State: _____

OTHER

Patient's Dentist: _____ Phone Number: _____

Patient's Physician: _____ Phone Number: _____

Who suggested the need for orthodontic treatment? _____

How did you hear about our office? _____

What is your main concern? _____

Is this your first orthodontic consultation? Yes ❑ or No ❑ if no, Office Name: _____

Ever had prior orthodontic treatment? Yes ❑ or No ❑ if no, Office Name: _____

NOW OR IN THE PAST, HAS THE PATIENT HAD:

MEDICAL HISTORY

Yes No ADHD OR ADD?
Yes No AIDS or HIV positive?
Yes No Anemia?
Yes No Asthma?
Yes No Autism, Asperger's or sensory issues?
Yes No Behavioral Issues?
Yes No Birth defects or hereditary problems?
Yes No Bone fractures, any major accidents?
Yes No Cancer, tumor, radiation treatment or chemotherapy?
Yes No Cardiovascular problem (heart defects, murmur or rheumatic heart disease)? Pre-med indicated? Yes or No
Yes No Cerebral palsy?
Yes No Diabetes?
Yes No Down syndrome?
Yes No Eating Disorder?
Yes No Endocrine or thyroid problems?
Yes No Excessive bleeding or bruising tendency, anemia or bleeding disorder?
Yes No Fainting spells, seizures, epilepsy?
Yes No Hepatitis, jaundice or liver problem?
Yes No High or low blood pressure?
Yes No Kidney disease?
Yes No Mental health issues, anxiety, bi-polar or depression?
Yes No Mononucleosis, tuberculosis, pneumonia?
Yes No Compromised immune system?
Yes No Rheumatoid or arthritic conditions?
Yes No Vision, hearing, tasting or speech difficulties?
Yes No Hospitalized recently:_____
Yes No Any other medical conditions we should be aware of? _____
Yes No Currently taking any medication?
_____
_____

FEMALE PATIENTS: pregnant? Yes or No

DENTAL HISTORY

Yes No Abnormal swallowing habit (tongue thrusting)?
Yes No Any relatives with similar tooth or jaw relationships?
Yes No Any pain or soreness in the muscles of the face or around the ears?
Yes No Any Issues with previous dental treatment?
Yes No Bleeding gums, bad taste or mouth odor?
Yes No Chipped or injured teeth? Primary or adult?
Yes No Concerned about spaced, crooked or protruding teeth?
Yes No Congenitally missing teeth?
Yes No Difficulty encountered in chewing or jaw opening or TMJ issues?
Yes No Food impaction between teeth?
Yes No History of decay/cavities?
Yes No Jaw fractures, cysts or infections?
Yes No Mouth breathing habit, snoring or difficulty in breathing?
Yes No Periodontal "gum problems" or treatment?
Yes No Permanent or extra teeth removed or present?
Yes No Root canals?
Yes No Teeth sensitive to hot or cold?
Yes No Thumb, finger habit? Until what age _____
Yes No Tooth grinding or jaw clenching?
Yes No Juice, sports drinks or pop consumed regularly?

ALLERGIES

Yes No Medications?
_____
_____
Yes No Metals? _____
Yes No Other? _____
_____
Yes No Local anesthetics (Novocaine or Lidocaine)?
Yes No Latex?

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date: _____