Northeast Orthodontic Specialists

Jacob Stadiem, DMD, MS

Date_____

Confidential Patient Information

A B C

Patient's Name _____ Called _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age ____ Social Security # _____ Sex ___

If patient is a minor, give parent's or guardian's name _____

Sports or Hobbies _____ Whom may we thank for referring you? _____

Confidential Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address _____ Email _____
Street City State Zip

How long at this address _____ Previous Address _____
(if less than 3 yrs) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policy Holder's Name _____ and Soc.Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

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MEDICAL/DENTAL HISTORY

Latest Revision: 7/25/2013

Physician's Name: _____ Phone: _____

General Dentist's Name: _____ Phone: _____

Are you currently under any medical treatment? Please list	☐ Yes	☐ No
Are you currently taking any medication? Please list the medication	☐ Yes	☐ No
Do you have allergies? (Sulphur, Penicillin, Novocaine, etc.) Please list	☐ Yes	☐ No
Do you have a latex allergy?	☐ Yes	☐ No
Do you have a nickel allergy?	☐ Yes	☐ No
Have you ever taken bisphosphonates, etc. for Osteoporosis (i.e. Fosamax)?	☐ Yes	☐ No
Do you have a heart condition?	☐ Yes	☐ No
Do you pre-medicate prior to dental visits?	☐ Yes	☐ No
Do you have sleep apnea?	☐ Yes	☐ No
Do you bleed easily?	☐ Yes	☐ No
Is there a tendency to faint or become dizzy?	☐ Yes	☐ No
Do you smoke or chew tobacco?	☐ Yes	☐ No
Do you have pain, clicking, and/or popping noises in your jaw?	☐ Yes	☐ No
Are you aware of either clenching or grinding of teeth?	☐ Yes	☐ No
Do you have frequent headaches? If so, how frequently?	☐ Yes	☐ No
Do you have ear problems? (Aches, ringing, dizziness, fullness)	☐ Yes	☐ No
Do you have difficulty breathing through the nose?	☐ Yes	☐ No
Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?	☐ Yes	☐ No
Are you aware of any speech problems, or are you in speech therapy?	☐ Yes	☐ No
Have you had your tonsils and/or adenoids removed?	☐ Yes	☐ No
Have you been informed of any extra or missing teeth?	☐ Yes	☐ No
Have there been any injuries to the teeth?	☐ Yes	☐ No
Have you had any permanent teeth extracted?	☐ Yes	☐ No
Have we treated any other family members? Name(s)	☐ Yes	☐ No

Has there been any history of any of the following:

☐ Joint Swelling ☐ Asthma ☐ TB ☐ Aids ☐ Kidney Disorder ☐ Liver Condition

☐ Epilepsy ☐ Rheumatic Fever ☐ Other major illnesses: _____

In your own words what is your chief concern? _____

Which of the following categories is **most** important to you (PLEASE MARK ONE)?

☐ Quality ☐ Cost ☐ Comfort ☐ Time

_____ _____ _____

Patient Signature Date Parent Signature

OTHER INFORMATION: Siblings and/or children under age 18

	Sibling/Child Name:	Birth Date:
1.		
2.		
3.		
4.		

FOR OFFICE USE ONLY

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