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

Physician's Name: _____ Phone: _____

General Dentist's Name: _____ Phone: _____

	Please Circle	
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 (Please Circle):

Joint Swelling Asthma TB AIDS Kidney Disease 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 Circle One)? Quality Cost Time Comfort

_____ _____ _____
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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