Dr. Traci R. Fernandes – Specialist in Orthodontics

PATIENT HISTORY - (PATIENT REGISTRATION FORM)

Patient full/ legal name ______ Sex ☐M ☐F Age ______

I prefer to be called (Nickname) ______ Previous surnames used ______

Birth Date ______ SS # ______ Email Address ______

Home address ______

Mailing address - ☐ Same or list if different ______

Phone Numbers Home # ______ Work # ______ Cell # ______

Employer's name ______ Occupation ______

Married ☐Y ☐N Spouse's name ______

Emergency contact ______ Phone # ______ Relationship ______

Whom may we thank for referring you? ______

Names of other family members being treated in our office ______

Please list any sports, hobbies or interests

MEDICAL HISTORY

For the following questions mark "Y" for yes and "N" for No. The answers are for office record only and are confidential. A thorough and complete history is vital to a proper orthodontic evaluation. **Have you ever been treated for**:

Anemia	☐Y ☐N	Bone Disorders or Osteoporosis	☐Y ☐N	Prolonged Bleeding	☐Y ☐N
Arthritis	☐Y ☐N	HIV Positive/AIDS	☐Y ☐N	Frequent Headaches	☐Y ☐N
Asthma	☐Y ☐N	Allergy/Hay Fever	☐Y ☐N	Fainting or Dizziness	☐Y ☐N
Cancer	☐Y ☐N	Rheumatic Fever	☐Y ☐N	Endocrine or Thyroid	☐Y ☐N
Epilepsy	☐Y ☐N	Heart Trouble	☐Y ☐N	Kidney Involvement	☐Y ☐N
Hepatitis	☐Y ☐N	Tuberculosis	☐Y ☐N	Liver Involvement	☐Y ☐N
Herpes	☐Y ☐N	Diabetes	☐Y ☐N	Nervous Disorders	☐Y ☐N

Are you in good health? ……………………. ☐Y ☐N If no, please explain ______

Have you seen a physician in the last 2 years? ☐Y ☐N If yes, please explain ______

Do you have a history of major illness? ……. ☐Y ☐N If yes, please explain ______

Have you ever had psychological counseling? ☐Y ☐N If yes, please explain ______

Any drugs or medications now being taken? ☐Y ☐N If yes, please list ______

Any allergies to medications, anesthetics, latex, acrylic, metals or other materials? ☐Y ☐N If yes, please explain ______

Have your adenoids or tonsils been removed? ☐Y ☐N If yes, at what age? ______

Have you ever used Phen-fen? ……………... ☐Y ☐N Do you smoke or chew tobacco? ☐Y ☐N

(For Women) Are you pregnant? …………... ☐Y ☐N

Has your physician recommended that you take antibiotic prophylaxis before dental procedures? ☐Y ☐N

Are you taking or have you ever taken Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Aredia ☐ Zometa ☐ None☐

Name of Physician City ___ Phone #

DENTAL HISTORY

Have there ever been injuries to the face, mouth or teeth? ☐ Y ☐ N If yes, please explain ______

Have wisdom teeth been extracted? …………………………… ☐ Y ☐ N ______

Have you been informed of missing or extra permanent teeth? ☐ Y ☐ N ______

Do you clench or grind your teeth? …………………………… ☐ Y ☐ N ______

Do you predominantly breathe through your nose? …………… ☐ Y ☐ N ______

Have you had any clicking/discomfort in the jaw joints near the ears? ☐ Y ☐ N ______

Have you had any periodontal treatment? ☐ Y ☐ N If yes, what type and when? ______

Have you ever sucked your finger/thumb? ☐ Y ☐ N If yes, until what age? ______

Do you have problems with your speech? ☐ Y ☐ N If yes, please explain ______

Have you had previous orthodontic examinations? ☐ Y ☐ N If yes, when? ________ Was treatment provided? ☐Y ☐ N

Are you apprehensive toward dental visits? ……... ☐ Y ☐ N If yes, please explain ______

What is your and/or dentist's orthodontic concern? ______

Date of last dental examination …………………... ______ Were X-rays taken? ☐ Y ☐ N

Name of Dentist City Phone #