CENTRAL ORTHODONTICS
MARIE MANSOUR DMD, MS

Patient Information

Date____________________

Patient's name____
Last First Middle

Address ____
Street City Zip

Home Phone_______________________ Birthdate________________ Social Security #____________________

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

Whom may we thank for referring you to our office?____

Responsible Party Information

Name____
Last First Middle

Residence ____
Street City Zip

Mailing Address____
Street City Zip

How long at this address?______ Home phone__________________________ Work phone ___________________

Previous Address (If less than 3 years)____

Social Security #______________________________ Birthdate__________________ Relationship to Patient __________

Employer______________________________________ Occupation_____________________ No. years employed _____

Spouse's Name____ Relationship to Patient____________________

Employer______________________________________ Occupation_____________________ No. years employed _____

Social Security # ____________________________ Birthdate __________________ Work Phone __________________

Dental Insurance Information

Insured's Name____ Insured's Social Security # ___________________

Insurance Company__________________________ Group No.__________________ Local No.____________________

Insurance Co. Address____ Phone No. ___________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name____ Insured's Social Security # _____________________

Insurance Company__________________________ Group No.__________________ Local No.____________________

Insurance Co. Address____ Phone No. ___________________

Emergency Information

Name of nearest relative not living with you ____

Complete address ____
Street City Zip

Phone ____

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

Signature (Parent's signature if minor) ____

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MEDICAL HISTORY

Physician______________________________ Date of Last Visit ____________________
Address______________________________ Phone ____________________
Please circle Yes or No (If Yes, please fill in details)
Yes No Is patient in good health?____________________
Yes No Is patient under care of a physician? If yes, explain____________________
Yes No Are you taking any medication? Birth Control? If yes, please list____________________
Yes No Are you allergic to any medication? ____________________
Yes No Are you allergic to latex?____________________
Yes No Do you have a history of a major illness? ____________________
Yes No Have you had any major operations? ____________________
Yes No Have you ever been involved in a serious accident?____________________
Yes No Has patient taken any weight loss medications (e.g. PhenFen)____________________
Yes No Does the patient smoke or use alcohol? Circle one or both and how often?____________________
Yes No Has the patient ever had a skin reaction to metal or jewelry?____________________
Yes No Does the patient have a cardiac pacemaker, artificial heart valve, heart murmur, or need to premedicate?___
Yes No Is there any family history of diabetes, heart murmur/problems or tumors?____________________
Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? ____________________
____

DENTAL HISTORY

Dentist______________________________ Date of last visit ____________________
What concerns you most about your teeth? ____________________
Yes No Are you presently in any dental pain?____________________
Yes No Have you ever experienced any unfavorable reaction to dentistry?(esp. local anesthetic/novacaine?) ______
Yes No Have you ever lost or chipped any teeth? ____________________
Yes No Have there been any injuries to face, mouth or teeth? ____________________
Yes No Is any part of your mouth sensitive to temperature or pressure? ____________________
Yes No Do your gums bleed when you brush? ____________________
Yes No Do you have any type of thumb or tongue habit? ____________________
Yes No Are you a mouth breather? ____________________
Yes No Have you ever seen an orthodontist? If yes, who and when? ____________________
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?__________
Yes No Has anyone in your family received orthodontic treatment? ____________________
How did they feel about the result? ____________________
What is your attitude toward receiving orthodontic treatment? ____________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?__________
Yes No Are you aware of your jaw clicking or popping?____________________
Yes No Are you aware of clenching your teeth during the day?____________________
Yes No Have you ever been told that you grind your teeth? ____________________
Yes No Do you have “tension” headaches? ____________________
Yes No Have you ever experienced chronic ringing in your ears?____________________
Yes No If the patient is under age 16, height of parents? Mom______ Dad______
Yes No Are you aware that some appointments will be during school/work hours? ____________________
Please list some hobbies or interests ____________________
Female Patients only:____________________
Yes No Are you pregnant? If yes how many months? ____________________
Yes No Has menstruation started? If so, when? ____________________

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Marie Mansour to perform a complete orthodontic evaluation.

Signature: ______________________________Date: ____________________
Medical History Update: Has there been any change in your health since your last dental appointment? If so, please explain:
____
Signature:______________________________ Date:____________________