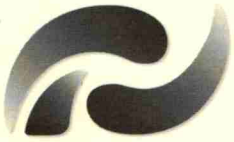

**SAMUEL S. BERRO, D.D.S. INC.**
ORTHODONTICS
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

## PATIENT INFORMATION

DATE _____

NAME _____ NICK NAME _____ MARITAL STATUS _____ SEX _____

ADDRESS _____ CITY _____ ZIP _____

YEARS AT THIS ADDRESS? _____ PHONE: HOME _____ CELL _____ WORK _____

SSN _____ BIRTHDATE _____ AGE _____ EMAIL _____

OCCUPATION _____ EMPLOYER _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____ PHONE: HOME _____ CELL _____ WORK _____

SSN _____ BIRTHDATE _____ AGE _____ EMAIL _____

OCCUPATION _____ EMPLOYER _____ YEARS EMPLOYED _____

INTERESTS OR HOBBIES _____

NAMES AND AGES OF CHILDREN AT HOME _____

NAME OF DENTIST _____ DATE OF LAST VISIT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DO YOU KNOW ANY PATIENTS IN OUR PRACTICE? WHO? _____

PLEASE CHECK REASONS FOR SEEKING AN ORTHODONTIC CONSULTATION:

☐ SUGGESTED BY DENTIST ☐ CROWDING ☐ SPACING ☐ BAD BITE ☐ OVERBITE ☐ EXCESSIVE WEAR

☐ OTHER _____

## RESPONSIBLE PARTY INFORMATION (if different)

NAME _____ MARITAL STATUS _____

ADDRESS _____ CITY/STATE _____ ZIP _____

HOW LONG AT THIS ADDRESS? _____ HOME PHONE _____ CELL PHONE _____

SSN _____ BIRTHDATE _____ WORK PHONE _____

OCCUPATION _____ EMPLOYER _____ YEARS EMPLOYED _____

## DENTAL INSURANCE INFORMATION

INSURED'S NAME _____ INSURED'S SSN _____

INSURANCE CO _____ GROUP # _____ INSURANCE PHONE _____

INSURANCE CO ADDRESS _____ EMPLOYER _____

DO YOU HAVE DUAL COVERAGE? ☐ YES ☐ NO IF YES:

INSURED'S NAME _____ INSURED'S SSN _____

INSURANCE CO _____ GROUP # _____ INSURANCE PHONE _____

INSURANCE CO ADDRESS _____ EMPLOYER _____

# MEDICAL HISTORY

PHYSICIAN'S NAME _____ CITY _____ LAST SEEN _____

YES NO *Are you experiencing any health problems? Explain* _____

YES NO *Do you have any history of major illness? Explain* _____

YES NO *Are you currently taking medications or drugs? Please list* _____

YES NO *Are you allergic to any medications or drugs? Please list* _____

YES NO *Women: Are you pregnant?*

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| YES NO ANEMIA | YES NO DIABETES | YES NO HEAD OR NECK PAIN | YES NO NERVOUSNESS |
| YES NO ARTHRITIS | YES NO DIZZINESS | YES NO HEART DISEASE | YES NO PROLONGED BLEEDING |
| YES NO ASTHMA | YES NO EPILEPSY | YES NO HEART MURMUR | YES NO RESPIRATORY DISORDERS |
| YES NO BONE DISORDER | YES NO EMOTIONAL DISORDER | YES NO HEPATITIS | YES NO RHEUMATIC FEVER |
| YES NO CANCER | YES NO FAINTING | YES NO HIV OR AIDS | YES NO TUBERCULOSIS |

☐ OTHER CONDITIONS OR PROBLEMS NOT MENTIONED ABOVE: _____

NEAREST RELATIVE IN CASE OF EMERGENCY _____ PHONE _____

# DENTAL HISTORY

YES NO *Injuries to face, mouth or teeth?*

YES NO *History of speech problems?*

YES NO *Abnormal swallowing habit (tongue thrusting)?*

YES NO *Mouth breathing habit, difficulty breathing?*

YES NO *Missing permanent teeth?*

YES NO *Extra permanent teeth?*

YES NO *Periodontal (Gum) problems?*

YES NO *Any teeth irritating cheek, lip or tongue?*

YES NO *Clicking or popping of the jaw?*

YES NO *Difficulty in opening, closing or chewing?*

YES NO *Pain or soreness in muscles of face or around the ears?*

YES NO *Clenching or grinding of the teeth while awake or asleep?*

YES NO *Would you mind wearing braces if needed?*

YES NO *Have you had any previous orthodontic treatment?*

YES NO *Has an orthodontist been consulted previously? Who?* _____ *Date* _____

YES NO *Have any family members had orthodontic treatment? Who?* _____

YES NO *Any other information that may be helpful?* _____

*If there are any changes to this history record or medical/dental status, I will so inform this practice.*

*Signature* _____ *Date* _____