TIMOTHY J. POSER, D.D.S., M.S., S.C.

ORTHODONTIST

Diplomate of the American Board of Orthodontics

Date: _____

Patient Information

Name: _____ Nickname: _____

Address: _____ Date of Birth: _____/_____/_____

_____ Phone Number: (_____) _____
City Zip Area Code

Employed by: _____ How long? ____ yrs. Occupation: _____

Business Phone Number: (_____) _____
Area Code

Marital Status:

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____ Business Phone Number: (_____) _____
Area Code

Employed by: _____ How long? ____ yrs. Occupation: _____

Patient''s Dentist: _____

Who may we thank for referring you to our office? _____

Responsible Party Information

Name: _____ Phone Number: (_____) _____

Address if different from patient's: _____

_____

Insurance Information

If you have orthodontic insurance, please provide the following information so that we can verify your benefits.

Primary Dental Insurance: _____ Insurance ID# OR Social Security #: _____

Name of Insured _____

Secondary Dental Insurance: _____ Insurance ID# OR Social Security #: _____

Name of Insured: _____

Please complete and return at your initial visit.

PIA

MEDICAL HISTORY

Patient's Name: _____ Date: _____

_____

Height: ____ft.____in. Weight: ____lbs.

Approximate date of last physical examination: _____ By whom: _____
month/year

Please circle Y (yes) or N (no) for the following questions.
Your answers are for our records only and are considered confidential.

Do you now have or ever had any of the following:

Y N Tuberculosis	Y N Respiratory Lung Disease	Y N ADD
Y N Epilepsy	Y N Kidney Problems	Y N Headaches
Y N Heart Condition	Y N Liver Disease	Y N Earaches
Y N Stroke	Y N Diabetes	Y N Glaucoma
Y N High Blood Pressure	Y N Herpes (oral cold-sores)	Y N Jaw Pain
Y N Low Blood Pressure	Y N Blood Disorders/Bleeding Problems	Y N Tonsillitis
Y N Inflammatory Rheumatism	Y N X-Ray/Radiation (cancer) Therapy	Y N Prosthetic (artificial) Joint
Y N Arthritis	Y N Rheumatic Fever	Y N Fainting Spells
Y N Hepatitis (type____)	Y N Ulcers	Y N Emotional Problems
Y N Venereal Disease	Y N Anemia	Y N Psychiatric Treatment
Y N AIDS or HIV Positive	Y N Asthma	Y N Drug Addiction

Y N Do you have any disease, condition or problem not listed above that we should know about?
If so, please list:

_____

_____

_____

Y N Do you have any allergies or drug sensitivity? If so, please list:

_____

_____

_____

Y N Are you taking any medications? If so, please list and give reasons for taking:

_____

_____

_____

Y N Have you ever been advised by your physician to take an antibiotic prior to any dental treatment?
Please inform our office if you need to be premedicated.

Y N Are you in good health?

Y N Women: Are you pregnant?
Please inform us if you are pregnant or if you become pregnant during orthodontic treatment.

Please continue on other side

DENTAL HISTORY

Approximate date of last examination: _____ (month/year) By whom: _____

Y N Have there been any injuries to your face, mouth, or teeth? Give details of any injuries:

_____

_____

_____

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

Y N Have you had any permanent teeth removed?

Y N Have you ever been treated for gum disease?

Y N Are you aware of sores, lumps, or irritated areas in your mouth?

Y N Has any member of the family received orthodontic treatment?
If so, were they satisfied with the results? _____

Do you now have or ever had any of the following habits?

Y N Grinding of teeth at night
Y N Mouth breathing
Y N Snoring

The following questions pertain to the TMJ (jaw joints):

Y N Do you have a history of TMJ problems?
Y N Have you been treated for a TMJ disorder?
Y N Does your jaw feel uncomfortable or unusual?
Y N Do you grind your teeth?
Y N Do you clench your teeth?
Y N Has your jaw ever locked?
Y N Do you experience soreness in the muscles of your face or ears?
Y N Do you notice clicking or popping in your joint?
Y N Do you have difficulty chewing or opening your mouth?

Y N Do you have any concerns regarding orthodontic treatment? If so, please list:

_____

_____

_____

I have completed the health and dental questionnaires and certify that the preceding information is true and correct. Dr. Poser's office will not be held responsible for any problems arising out of inadequate information not disclosed. I grant authority to the doctor and his staff to perform all procedures and treatment in my best interest.

_____ Signature

_____ Date