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

Father's Name: _____ Mother's Name: _____

Employed by: _____ Employed by: _____

How long? _____ Occupation: _____ How long? _____ Occupation: _____
Yrs. Yrs.

Business Phone Number: (_____)_____ Business Phone Number: (_____)_____
Area Code Area Code

Marital Status of Parents:

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed School child attends: _____

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.

PIC

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.

Does the patient now have or ever had any of the following:

Y N Tuberculosis
Y N Epilepsy
Y N Heart Condition
Y N Stroke
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Inflammatory Rheumatism
Y N Arthritis
Y N Hepatitis (type_____)
Y N Venereal Disease
Y N AIDS or HIV Positive

Y N Respiratory Lung Disease
Y N Kidney Disorders
Y N Liver Disease
Y N Diabetes
Y N Herpes (oral cold-sores)
Y N Blood Disorders/Bleeding Problems
Y N X-Ray/Radiation (cancer) Therapy
Y N Rheumatic Fever
Y N Ulcers
Y N Anemia
Y N Asthma

Y N ADHD
Y N Headaches
Y N Earaches
Y N Glaucoma
Y N Jaw Pain
Y N Tonsillitis
Y N Prosthetic (artificial) Joint
Y N Fainting Spells
Y N Emotional Problems
Y N Psychiatric Treatment
Y N Drug Addiction

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

_____

_____

Y N Does the patient have any drug sensitivity or allergies (e.g latex)? If so, please list:

_____

_____

Y N Is the patient taking any medications? If so, please list and give reasons for taking:

_____

_____

Y N Has the patient ever been advised by his/her physician to take an antibiotic prior to any dental treatment?
Please inform our office if patient needs to be premedicated.

Y N Is the patient in good health?

Y N Is the patient's height and weight normal for age?
What is the approximate increase in height in the last 6 months? _____inches

Y N Has the patient reached puberty?

Girls - started menstruating
Boys - voice changed

Y N Has the patient's tonsils and adenoids been removed?

Does the patient have a tendency for the following:

Y N Colds
Y N Sore Throats
Y N Ear Infections

Please continue on other side

DENTAL HISTORY

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

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

_____

_____

Y N Has the patient been informed of any missing or extra permanent teeth?
Y N Has the patient had any primary (baby) or permanent teeth removed?
Y N Has the patient ever been treated for gum disease?
Y N Is the patient aware of sores, lumps, or irritated areas in the mouth?
Y N Does the patient have any speech problems?
Y N Has any member of the family received orthodontic treatment?
Were they satisfied with the results? _____

Does the patient now have or ever had any of the following habits?

Y N Thumb or finger sucking. If yes, at what age did this habit stop? _____
Y N Mouth breathing
Y N Snoring

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

Y N Does the patient have a history of TMJ problems?
Y N Has the patient been treated for a TMJ disorder?
Y N Does the patient's jaw feel uncomfortable or unusual?
Y N Does the patient grind his/her teeth at night?
Y N Does the patient clench his/her teeth?
Y N Has the patient's jaw ever locked?
Y N Does the patient experience soreness in the muscles of his/her face or ears?
Y N Does the patient notice clicking or popping in his/her joint?
Y N Does the patient have difficulty chewing or opening his/her mouth?

Patient's primary (baby) teeth came in: ☐ Early ☐ Average ☐ Late

Patient's dental and facial features resemble: ☐ Mother ☐ Father ☐ Both ☐ Neither

Y N Does the patient have any concerns regarding orthodontic treatment? If so, please list:

_____

_____

Y N As a parent, do you have any concerns regarding your child's treatment? If so, please list:

_____

_____

Patient's attitude toward orthodontic treatment:

____Wants Treatment ____Unwilling But Agrees ____Uncooperative

I, the undersigned, 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 child's best interest.

_____ _____

Signature of Parent or Guardian Date