Cameron L. Aboudara, D.D.S., M.S.

Specialist in Orthodontics

Patient Number

Date

1 BEGIN HERE: ADOLESCENT PATIENT INFORMATION

Name:_____ _____ Address:_____
First Mi Last Nickname

Phone:_____ Birthday_____ Age:_____ Sex:_____ City:_____ State:_____ Zip:_____

2 BEGIN HERE: ADULT PATIENT INFORMATION

FATHER or SELF/GUARDIAN INFORMATION

Name:_____
First Mi Last

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Birthday:_____ Cell #:_____

S.S. #:_____ Email: _____

EMPLOYER/INSURANCE INFORMATION

Employer Name:_____

Employer Address:_____

Employer City:_____ State:____ Zip:_____

Number of Years Employed____ Occupation_____

Orthodontic Coverage? Yes___ No___

Insurance Company Name:_____

Insurance Address:_____

Insurance City:_____ State:_____ Zip:_____

Insurance Phone:_____ ext:_____

Group #:_____ Local or Union #:_____

Benefit: _____

MOTHER or SPOUSE INFORMATION

Name:_____
First Mi Last

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Birthday:_____ Cell #:_____

S.S. #:_____ Email: _____

EMPLOYER/INSURANCE INFORMATION

Employer Name:_____

Employer Address:_____

Employer City:_____ State:____ Zip:_____

Number of Years Employed____ Occupation_____

Orthodontic Coverage? Yes___ No___

Insurance Company Name:_____

Insurance Address:_____

Insurance City:_____ State:_____ Zip:_____

Insurance Phone:_____ ext:_____

Group #:_____ Local or Union #:_____

Benefit: _____

3 OTHER INFORMATION

Who is the Responsible Party:_____ Who may we thank for referring you?_____

Dentist Name:_____ Sports or Hobbies:_____

Physician Name:_____ Other Children:_____ Birthday:_____

School Name:_____ Grade:_____ Other Children:_____ Birthday:_____

4 MEDICAL INFORMATION

	YES	NO
Any Heart Disease:		
Any Respiratory Disease:		
Any Blood Disease:		
Any Liver Disease:		
Any Thyroid Disease:		
Any Kidney Disease:		
H.I.V. Positive:		
Any Venereal Disease:		
Any Intestinal Disease:		
Any Bone Disease:		
Any Nervous /Emotional Problems:		
Any High or Low Blood Pressure:		
Any Endocrine Problems:		
Any Problems with Wounds Healing:		
Any Tumors or Cancer:		

	YES	NO
Acquired Immune Deficiency Syndrome:		
Is Patient Under Medical Care:		
Rheumatism or Arthritis:		
Is the Patient taking any Medications:		
A History of Fainting or Dizziness:		
Does the Patient have a Drug Addiction:		
Is the Patient Pregnant at this Time:		
Measles/Mumps/Chicken Pox:		
Does the Patient Smoke:		
Has the Patient ever had Fever Blisters:		
Is Height & Weight Normal for Age:		
Is the Patient in Good Health:		
Has the Patient had a Physical this Year:		
Has the Patient Reached Puberty:		
If Female: Age began menstruating:		

	YES	NO
Heart Murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		

	YES	NO
Asthma or Hay Fever:		
Tuberculosis:		
Any Broken Bones:		
Prolonged Bleeding:		
Yellow Jaundice:		
Radiation Therapy:		
Chemical Therapy:		
Blood Transfusions:		
Latex Allergy:		

Is the Patient Allergic to Anything: _____

What: _____

List any Medications: _____

Are you aware of any other disease, condition, or problem not listed above that we should know about:

If Yes, What: _____

5 DENTAL HISTORY

	Yes	No
Has the Patient Seen a General Dentist in the Last Year:		
Any Pain, Clicking or Discomfort In or Near the Ears:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Have You Been Informed of Missing or Extra Permanent Teeth:		
Are You Aware of Any **"Gum"** Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		
Do You Feel the Patient can Benefit From Orthodontic Treatment:		
Is the Patient Happy with Their **"SMILE"**:		
Does the Patient Want to Improve Their **'SMILE"** and **"BITE"**:		
Would the Patient Mind Wearing **"BRACES"**:		

Does the Patient Have or Ever Had Any of the Following Habits:

	Yes	No
Cheek, Tongue or Lip Chewing:		
Thumb Sucking:		
Mouth Breathing:		
Finger Nail Biting:		

	Yes	No
Clenching Teeth:		
Tongue Thrusting:		
Grind Teeth:		
Speech Problems:		

Has the Patient Been Examined by an Orthodontist Before: _____

If Yes, When: _____

Have Other Members of the Family had Orthodontic Treatment: _____

If Yes , Were You Happy With the Results: _____

If No, Why: _____

In Your Own Words What is the Orthodontic Problem: _____

What Would you Like Orthodontic Treatment to Accomplish: _____

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

Patient Signature _____ **Date** _____ **Parent Signature** _____

6 TMJ HISTORY (IF APPLICABLE)

Do you have clicking, popping, or grating noises in your
RIGHT JAW JOINT? .....YES . . .NO
LEFT JAW JOINT? .....YES . . .NO
When did you first notice the noise? _____
Has the noise recently become more pronounced? .....YES . . .NO
Do you have pain in or around RIGHT JAW JOINT? . . .YES . . .NO
LEFT JAW JOINT? . . . .YES . . .NO
When did you first notice the pain? _____
Has the pain recently become more pronounced? .....YES . . .NO
When is the pain worse? Mornings _____ Evenings _____
At Meals _____ No Specific Time _____
What kind of pain? Dull _____ Continuous _____ Throbbing _____
Stabbing _____ Intermittent _____ Other _____
Does the pain feel like it is in your ear? .....YES . . .NO
Do you think your hearing has been affected? .....YES . . .NO
Are our daily activities affected? .....YES . . .NO
Are you taking or have you taken medication for symptoms related to your jaw? .....YES . . .NO
Did anything occur that might be related to the onset of this condition? .....YES . . .NO
Explain: _____

Do you have difficulty chewing? .....YES . . .NO
Has your mouth ever locked open so you were unable to close it? .....YES . . .NO
Explain: _____
Have you ever had problems opening your mouth wide? . .YES . . .NO
Please indicate the time sequence in which you became aware of the following symptoms (1st, 2nd, etc.) and list only those which apply to you: Pain ___ Noise ___ Limited Opening ___ Locking ___ Other ___
What aspect of your symptoms concern you the most? _____
_____
Are you aware of clenching your teeth? .....YES . . .NO
Do you grind your teeth? .....YES . . .NO
Has there been a recent change in your lifestyle such as marital status, childbirth, employment, death in your immediate family, or any other stressful events? .....YES . . .NO
Does nervous tension seem to affect you? .....YES . . .NO
Have you had problems with other joints? .....YES . . .NO
Have you had orthodontic treatment? .....YES . . .NO
Have you had recent dental treatment? .....YES . . .NO
Have you had x-rays taken for these symptoms? .....YES . . .NO