Welcome to DeFelice Orthodontics!

Please take a few moments to fill out this necessary information that will enable us to better serve you. Our staff will be happy to assist you with any questions you may have.

PATIENT'S INFORMATION

Patient's Name: _____ Age: ____ Birth Date: _____ Sex: M/F _____

Address: _____ City: _____ State: _____ Zip: _____

Patient lives with: _____ Home Number: _____

Preferred Name: _____ Work Number: _____

E-mail: _____ Interests/Hobbies: _____

FAMILY INFORMATION

Mother's Name: _____ Phone: _____ Occupation: _____

Address (if different from above): _____

Father's Name: _____ Phone: _____ Occupation: _____

Address (if different from above): _____

Other Children in Family (Name & Age): _____

MEDICAL HISTORY

Physician: _____ Last visit: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Are you under a physician's care presently? Y/N What condition? _____

Date Updated: | | | | | |

IS THERE ANY IMMEDIATE FAMILY HISTORY OF: (PLEASE CIRCLE)

Y/N	Heart Disease	Y/N	Kidney Disease	Y/N	Nasal Blockage	Y/N	Emotional Problems
Y/N	Rheumatic Fever	Y/N	Diabetes	Y/N	Drug/Alcohol Use	Y/N	Psychiatric Therapy
Y/N	Heart Murmur	Y/N	Seizures	Y/N	Hepatitis/Jaundice	Y/N	Digestive Disorder
Y/N	High Blood Pressure	Y/N	Asthma	Y/N	Tuberculosis	Y/N	Hospitalization/Surg.
Y/N	AIDS/HIV+	Y/N	Arthritis	Y/N	Thyroid Disease	Y/N	Blood/Bleeding Disorder
Y/N	Frequent Colds	Y/N	Birth Defect	Y/N	Major Illness	Y/N	Unusual Childhood Disease

If you answered YES to any of the above, please explain. _____

_____

Are you taking any medications? Y/N What? _____

Do you have any food/drug allergies? Y/N What? (ie.penicillin, sulfa, latex, food, metals) _____

GENERAL INFO

Has Patient reached (Menstruation) Puberty? Y/N When? _____
Does the patient play a musical instrument? Y/N Which? _____
Does any relative have a similar bite? Y/N Who? _____
Patient looks like: Mom Dad Patient Height: ft. __ in. ____ Father: ft. __ in. __ Mother: ft. __ in. ___
Other relatives being treated here: _____

ORAL HEALTH HISTORY

Dentist: _____ Last visit: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Why are you seeking treatment? _____ Referred by: _____

Do you consider treatment in this case to be mainly for: Health Cosmetics Psychological Other

_____

What would you like treatment to accomplish? _____

Would you like improvement in facial appearance? Y/N How? _____

IS THERE ANY HISTORY OF: (PLEASE CIRCLE)

Y/N	Clicking of jaw/joints (TMJ)	Y/N	Tongue Thrusting/habit	Y/N	Prior Orthodontic Treatment
Y/N	Pain in Jaw Joints (ears)	Y/N	Grinding teeth (Day/Night)	Y/N	Extra teeth
Y/N	Injuries to the teeth	Y/N	Pen, lip or nail biting	Y/N	Extraction of teeth
Y/N	Injuries to the face	Y/N	Thumb /finger sucking	Y/N	Missing teeth
Y/N	Difficulty Chewing	Y/N	Chewing gum	Y/N	Speech problem
Y/N	Fever blisters/Ulcers	Y/N	Mouth breathing	Y/N	Dry mouth

If you answered YES to any of above, please explain WHAT happened and WHEN? _____

_____

Please list any other information which you feel may be of value in the treatment. _____

_____

FINANCIAL

Insurance Subscriber: _____ Birth Date: _____
Employer: _____ SS# _____ Work Phone: _____
Employer Address: _____ City: _____ State: ___ Zip: _____
Insurance Company: _____ ID# _____ Group # _____
Orthodontic Coverage: Y/N What Percentage? ____ % Max. Benefit? $ _____ Patient Portion? _____
Secondary Insurance? Y/N Insurance Company: _____ ID# _____ Group # _____

To the best of my knowledge, all the preceding answers are true and correct. I hereby give permission to Dr. Greg DeFlice and his clinical team to take necessary x-rays, photos or study models to enable complete diagnosis as well as use of these records for educational purposes.

Person responsible for account: _____

Patient, Parent or Guardian Signature _____ Relation _____ Today's Date _____