Monumental Smiles

Dave F. Proietti DDS, PC
Board Certified Orthodontic Specialist

Welcome to our office

Administrative and Health History Form

Patient Information

Patient's Name_____Sex_____
Last First Middle Nickname

Address_____
Street City State Zip

Home Phone_____Birthdate _____Age_____Social Security # _____
Family Dentist _____Physician _____Grade and School_____
If patient minor, give parent's or guardian's name_____
Brother's: Name and date of birth_____
Sister's: Name and date of birth_____
Whom may we thank for referring you to our office?_____

Responsible Party Information

Name_____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____Home Phone_____Work Phone_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Social Security #_____Birthdate_____Relationship to Patient_____
Employer_____Occupation_____No. Years Employed_____
Spouse's Name_____Work phone_____
Last First Middle

Employer_____Occupation_____No. Years Employed_____
Social Security #_____Birthdate_____Relationship to Patient_____

Dental Insurance Information

(1) Insured's Name_____Insured's Soc. Sec #_____
Insurance Company_____Group No. _____Telephone#_____
Insurance Address_____
Do you have dual coverage? Yes ❒ No ❒ If yes:
(2) Insured's Name_____Insured's Soc. Sec #_____
Insurance Company_____Group No. _____Telephone#_____
Insurance Address_____

Emergency Information

Name of nearest relative not living with you_____
Complete Address _____
Phone_____

I hereby state that the information on this form is true and correct to the best of my knowledge and understand that where appropriate, credit bureau reports may be obatined. I agree to allow Dr. Proietti to contact my family dentist, physician and other health care professionals as required to permit proper treatment.

_____
Signature (parent or guardian) Date
Updates (date & initial) _____ _____ _____ _____ _____ _____ _____

MEDICAL HISTORY

HAS PATIENT HAD ANY OF THE FOLLOWING:	YES	NO
ARTHRITIS	❒	❒
CANCER	❒	❒
AIDS/HIV	❒	❒
HERPES	❒	❒
VENEREAL DISEASE	❒	❒
ULCERS	❒	❒
ASTHMA	❒	❒
TUBERCULOSIS	❒	❒
DIABETES	❒	❒
FAINTING/DIZZINESS	❒	❒
NERVOUS DISORDER	❒	❒
HEPATITIS	❒	❒
HEART PROBLEMS/HEART MURMUR	❒	❒
RHEUMATIC FEVER	❒	❒
BLEEDING PROBLEMS	❒	❒
KIDNEY PROBLEMS	❒	❒
MUSCULAR DISORDER	❒	❒
HORMONAL DISORDER	❒	❒
BONE DISORDER	❒	❒
LIVER DISORDER	❒	❒
EPILEPSY	❒	❒
ALLERGIES	❒	❒
REMOVAL OF TONSILS AND ADENOIDS	❒	❒
FREQUENT HEADACHES	❒	❒
OTHER	❒	❒

	YES	NO
WOULD YOU LIKE TO DISCUSS PATIENT'S HEALTH HISTORY WITHOUT CHILD PRESENT?	❒	❒
PATIENT IS IN GOOD HEALTH	❒	❒
PATIENT IS UNDER PHYSICIAN'S CARE	❒	❒
IF SO, FOR WHAT REASON		
ARE THERE ANY MEDICAL CONDITIONS REQUIRING SPECIAL CONSIDERATION?	❒	❒
IF SO, DESCRIBE		
IS THERE ANY HISTORY OF THE FOLLOWING:		
ALLERGIC TO MEDICINES	❒	❒
HOSPITALIZATION OR SURGERY	❒	❒
FREQUENT COLDS, SORE THROAT OR EAR INFECTIONS	❒	❒
PHYSICAL HANDICAPS	❒	❒
PSYCHIATRIC DISORDER	❒	❒
LEARNING DISORDERS	❒	❒
COORDINATION PROBLEMS	❒	❒
FOR FEMALES ONLY:		
IS THE PATIENT PRESENTLY PREGNANT?	❒	❒
DOES THE PATIENT TAKE BIRTH CONTROL PILLS?	❒	❒

DENTAL HISTORY

	YES	NO	
DO YOU HAVE ANY SWALLOWING OR CHEWING PROBLEMS?	❒	❒	
DO YOU HAVE ANY SPEECH DIFFICULTIES?	❒	❒	
IS THERE A HISTORY OF FINGER OR THUMB-SUCKING	❒	❒	
AGE STOPPED			
DO YOU BREATHE THROUGH YOUR MOUTH OR NOSE?			
SNORING?	❒	❒	
HAVE YOU HAD ANY BLOWS OR INJURIES TO THE: (CIRCLE) TEETH? FACE? JAWS?	❒	❒	
DO ANY TEETH CAUSE PAIN OR ACHE AT PRESENT?	❒	❒	
IF YES, UNDER WHAT CIRCUMSTANCES?			
IS THERE A HISTORY OF GRINDING OR CLENCHING TEETH?	❒	❒	
DAY? NIGHT?			
HAVE YOU HAD ANY DIFFICULTY IN YOUR JAW JOINT?	❒	❒	
PAIN? CLICKING? POPPING? OPENING OR CLOSING?	❒	❒	

HOW LONG SINCE YOUR LAST DENTAL CHECK-UP? _____ HOW OFTEN? _____

HAVE ANY TEETH BEEN EXTRACTED BY A DENTIST? ❒ ❒ REASON _____

HAS THERE BEEN ANY TREATMENT FOR: (CIRCLE) ROOT CANAL GUM DISEASE EXTENSIVE CAVITIES

WHAT IS YOUR REASON FOR SEEKING TREATMENT? _____

_____

HAVE YOU PREVIOUSLY CONSULTED AN ORTHODONTIST? YES NO DATE _____

WERE ANY X-RAYS TAKEN? YES NO

DO YOU HAVE ANY INTEREST IN BRACES THAT ARE CLEAR? YES NO

WOULD YOU LIKE TO DISCUSS FINANCES WITHOUT CHILD PRESENT? YES NO