Novick ORTHODONTICS

# Adult New Patient Form

## *PATIENT INFORMATION*

Name _____Date_____

Nickname_____

Birth date _____/_____/_____Age_____❑ M ❑ F

Address_____

City _____State _____Zip code _____

Previous address (if less then 3 years)_____

_____

Cell #_____ Home #_____

Wk # _____ Marital Status❑ S ❑ M ❑ D

Email_____

SSN_____DL#_____

Employer_____

Job title _____No of years employed_____

Favorite Sports or Hobbies_____

In case of Emergency Contact_____

Phone #_____Relationship_____

## *INSURANCE INFORMATION* ❑ YES ❑ NO

**Primary Insurance Company**_____

Policy Holder's Name _____

Policy Holder's Birth date _____/_____/_____

Contact #_____Group #_____

Subscriber #_____Employer_____

**Secondary Insurance Company**_____

Policy Holder's Name _____

Policy Holder's Birth date _____/_____/_____

Contact #_____Group #_____

Subscriber #_____Employer_____

## *HOW DID YOU HEAR ABOUT OUR OFFICE?*

❑ Dentist_____

❑ Friend_____

❑ Internet_____

❑ Other_____

## *SPOUSE'S INFORMATION*

Name _____Birth date_____

Address_____

City _____State _____Zip code_____

Home #_____Wk #_____

Employer _____Job title_____

No. of years employed _____Marital Status ❑ S ❑ M ❑

SSN_____DL#_____

## *PERSON FINANCIALLY RESPONSIBLE*

Name_____ Birth date_____

Address_____

City_____ State_____ Zip code_____

Cell #_____Wk #_____

Home # _____

Employer _____Job title_____

No. of years employed _____Marital Status ❑ S ❑ M ❑ D

SSN_____DL#_____

**Orthodontics for patients of all ages!!!**

**Please complete the Dental and Medical History on the following pages**
**Thank You!**



**Darshana Novick D.D.S., M.S.**
**7351 W. North Ave River Forest, IL 60305**
**708-366-2300**

## Dental History

Name of Dentist:_____ Last Visit: _____

In your words, what is the orthodontic concern?_____

Have you had any previous orthodontic treatment or consultation? ❑ Yes ❑ No

If so, what work was completed, and by whom?_____

Has any other family member had orthodontics?_____

If so, what work was completed and by whom?_____

Were the results acceptable? ❑ Yes ❑ No

**Has there every been a history of:**

| | | |
|---|---|---|
| Clenching and/or grinding teeth during the day | ❑ Yes | ❑ No |
| Clenching and/or grinding teeth during sleep | ❑ Yes | ❑ No |
| Muscular soreness around head and neck | ❑ Yes | ❑ No |
| Pain or discomfort in the jaw joints | ❑ Yes | ❑ No |
| Jaw joints popping or clicking | ❑ Yes | ❑ No |
| Jaw joints locking open or closed | ❑ Yes | ❑ No |
| Difficulty on opening and closing mouth | ❑ Yes | ❑ No |
| Pain in front of ear or ear pain | ❑ Yes | ❑ No |
| Ringing in the ears | ❑ Yes | ❑ No |
| An adverse reaction during a medical or dental procedure | ❑ Yes | ❑ No |
| Serious trauma or injury to the teeth, face, jaws or head | ❑ Yes | ❑ No |
| When biting teeth together, my bite feels uncomfortable | ❑ Yes | ❑ No |

Other information that may be helpful: _____

**Do you exhibit any of the following speech problems:**

| | | |
|---|---|---|
| Tongue Tied | ❑ Yes | ❑ No |
| Problems sounding letters | ❑ Yes | ❑ No |
| Seeing a speech pathologist | ❑ Yes | ❑ No |

Other information that may be helpful: _____

**Do you have any of the following habits:**

| | | |
|---|---|---|
| Thumb or finger sucking | ❑ Yes | ❑ No |
| Breathing through mouth while awake | ❑ Yes | ❑ No |
| Tongue biting/chewing | ❑ Yes | ❑ No |
| Cheek biting/chewing | ❑ Yes | ❑ No |
| Lip biting/chewing | ❑ Yes | ❑ No |
| Fingernail biting | ❑ Yes | ❑ No |

**Will you best describe your attitude toward orthodontic treatment:**

❑ Wants treatment ❑ Treatment is necessary ❑ Unwilling, but agrees ❑ Uncooperative

## Patient's Medical History

Are you under the care of a physician for any specific condition? ❑ Yes ❑ No

If yes, please describe_____

Are you taking any medication? ❑ Yes ❑ No

If yes, please list_____

Any Drug Sensitivity or Drug Allergies? ❑ Yes ❑ No

If yes, please explain _____

Have you ever received blood transfusion? ❑ Yes ❑ No

If yes, please explain reason for blood transfusion _____

Any major or unusual illnesses? ❑ Yes ❑ No

If yes, please explain _____

Are there any special considerations that we need to be aware of? ❑ Yes ❑ No

If yes, please explain _____

**Please check if you have had any of the following:**

| | | |
|---|---|---|
| ❑ Heart Murmur | ❑ Anemia | ❑ Blood Disease |
| ❑ Herpes | ❑ Jaundice | ❑ Tuberculosis |
| ❑ Tonsillitis | ❑ Bone Disorders | ❑ Difficulty breathing |
| ❑ Heart Disease | ❑ Polio | ❑ Allergic to Latex |
| ❑ Prolonged Bleeding | ❑ Diabetes | ❑ Hepatitis |
| ❑ Frequent Colds or Flu | ❑ Rheumatic/Scarlet Fever | ❑ Problems while asleep |
| ❑ Rheumatism or Arthritis | ❑ Frequent Fever Blisters | ❑ Seasonal Allergies |
| ❑ Any Thyroid Disease | ❑ Any Respiratory Disease | ❑ Bisphosphonates |
| ❑ Endocrine or Growth Problems | ❑ AIDS/HIV positive | ❑ Asthma or hayfever |
| ❑ Allergies | ❑ Convulsions or Epilepsy | ❑ Blood pressure problems |
| ❑ Artificial joints or heart valves | ❑ Headaches (more than normal) | ❑ Tonsillitis |

❑ Tonsils Removed? If checked, please list age when removed: _____

❑ Adnoids Removed? If checked, please list age when removed: _____

Are you pregnant or is there a possibility that you could be pregnant? ❑ Yes ❑ No

Have you currently been advised or have been advised in the past to take antibiotics? ❑ Yes ❑ No

Other Allergies present that were not mentioned above, please list: _____

## Authorization

I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate.
I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there are any changes in my dental or medical status, I will inform Dr. Novick.

Signature_____Date_____