

Robert A. Ritucci, D.M.D.

Specialist In Orthodontics
For
Children, Adolescents & Adults

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

E-Mail Address _____

Occupation _____ Birthdate _____ Age _____ Sex _____ Social Security # _____

Marital Status _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you to the office? _____

Spouse's Information

Spouse's Name _____
Last First Middle

Address _____
Street City State Zip

E-Mail Address _____

Occupation _____ Birthdate _____ Age _____ Sex _____ Social Security # _____

Home Phone _____ Work Phone _____

Financial Responsible Party Information

Who is financially responsible for the account? _____ patient _____ spouse _____ both _____ other

Name _____
Last First Middle

Residence _____
Street City State Zip Own Rent

Mailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

E-Mail _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of years Employed _____

Dental Insurance Information

Insured's Name _____ Insured's Social Security # _____

Dental Insurance Company _____ Group / Policy Number _____

Dental Insurance Co. Address _____ Phone _____

Insured's Employer _____

DOES THIS PLAN COVER ORTHODONTICS? YES NO If yes, what are the benefits: _____

Do you have secondary **dental** insurance coverage? (circle one) YES NO If yes: _____

Insured's Name _____ Insured's Social Security # _____

Dental Insurance Company _____ Group / Policy Number _____

Dental Insurance Co. Address _____ Phone _____

Insured' Employer _____

DOES THIS PLAN COVER ORTHODONTICS? YES NO If yes, what are the benefits: _____

Emergency Information

Name _____

Complete Address _____

Phone Number _____

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

Signature _____ Date _____

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Adult History

Patient Name _____

What is your chief concern for us at this visit? _____

** Please circle Y (yes) N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.

Medical History

- Y N Are you in excellent health?
My last physical exam was _____ (month/year) Physician's name / phone _____
- Y N Has there been any change in your general health within the last year? If yes, explain. _____
- Y N Are you under the care of a physician? If so, what is being treated? _____
- Y N Have you had a serious illness/hospitalization in the past 5 years? If so, for what? _____
- Y N Are you taking any medications (i.e. Non-prescription, OTC, Herbals)? _____
- Y N Does the patient smoke or use tobacco products (i.e. chew)? If yes, how much: _____

Allergies or drug reactions to:

- | | |
|---|--|
| Y N Latex? | Y N High or low blood pressure? |
| Y N Nickel? | Y N Have you ever taken a Bis-phosphonate drug? |
| Y N Penicillin or other antibiotics? | Y N Have you ever taken the drug Phen-Fen? |
| Y N Sulfa drugs? | Y N Cardiovascular disease (heart trouble, attack angina, arteriosclerosis, stroke) |
| Y N Aspirin, Ibuprofen, Tylenol? | Y N Damaged or artificial heart valves, including heart murmur of rheumatic heart disease? |
| Y N Local anesthetics? | Y N Cardiac pacemaker? |
| Y N Codeine or other narcotics? | Y N Require pre-medication before dental visits? |
| Y N Other? _____ | Y N Arthritis or joint problems or artificial joints/limbs? |
| Y N Respiratory problems, emphysema? | Y N Bone disorder, fractures or trauma to face or jaw? |
| Y N Asthma, hay fever, sinus trouble, hives? | Y N Kidney trouble? |
| Y N Persistent swollen neck glands? | Y N Birth defects or hereditary problems? |
| Y N Thyroid or endocrine problems? | Y N Vision, hearing, tasting or speech difficulty? |
| Y N Diabetes? | Y N Tuberculosis, mono, polio, pneumonia? |
| Y N Hepatitis, jaundice or liver disease? | Y N Persistent cough greater than 3 weeks duration? |
| Y N AIDS or HIV infection? | Y N Cough that produces blood? |
| Y N Sexually transmitted disease? | Y N Frequent headaches, colds or sore throats? |
| Y N Substance abuse problem (past or present)? | Y N Stomach ulcer or hyperacidity? |
| Y N Mental health or behavioral problems? | Y N Skin problems? |
| Y N Fainting spells or seizures? | Y N Tumor or growth (cancerous or benign)? |
| Y N Epilepsy or other neurological disease? | Y N Radiation therapy or Chemotherapy? |
| Y N Problems with the immune system? | Y N Females: Are you pregnant? |
| Y N Abnormal bleeding on blood transfusion? | Y N Are you taking birth control pills? |
| Y N Blood disorder such as anemia, hemophilia, leukemia? | |
| Y N Do you have any disease, condition or problem not listed above that you think we should know about? | |

If so, please explain _____

Dental History

Name of patient's dentist _____ Date of last dental exam _____ How often do you brush: _____ floss _____

- | | | | | | |
|---|---|---|---|---|--|
| Y | N | Chipped or injured teeth? | Y | N | History of missing or extra teeth? |
| Y | N | Teeth sensitive to hot or cold, throb or ache? | Y | N | Have any permanent teeth been removed? |
| Y | N | Jaw fractures, cyst, mouth infections? | Y | N | Have wisdom teeth been removed? |
| Y | N | Previous root canal therapy? | Y | N | Teeth that irritate tongue, cheek, lip, palate etc.? |
| Y | N | Bleeding gums or bad taste/mouth odor? | Y | N | Previous orthodontic treatment or exam? |
| Y | N | Previous or current periodontal (gum) problems? | Y | N | Numerous fillings? |
| Y | N | Problems with food trapped between teeth? | Y | N | Loose or damaged restorations or fillings? |
| Y | N | Frequent canker sores or cold sores? | Y | N | Thumb, finger or sucking habit as a child? |
| Y | N | Mouth breathing habit or snoring troubles? | Y | N | Loose or shifting teeth? |
| Y | N | Abnormal swallowing (tongue thrust)? | Y | N | Is all dental work completed at this time? |
| Y | N | Have you had a negative dental experience? | Y | N | Do you use any forms of fluoride? |

TMJ History

- | | | | | | |
|---|---|---|---|---|---|
| Y | N | Have you had a TMJ screening? | Y | N | Do you have pain in your jaw joint? |
| Y | N | Do you have a history of jaw joint problems? | Y | N | Do you experience soreness in the muscles of your face or around ears? |
| Y | N | Have you been treated for "TMJ"? | Y | N | Do you notice clicking or popping in your jaw joint or ringing in the ears? |
| Y | N | Do you grind your teeth? | Y | N | Do you have difficulty chewing or opening your mouth? |
| Y | N | Do you clench your teeth? | | | |
| Y | N | Has your jaw ever locked? | Y | N | |
| Y | N | Does your bite feel uncomfortable or unusual? | | | |

Patient Motivation For Orthodontic Treatment

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (circle the words, **more**, **less**, **forward**, etc.)

Teeth – If your teeth could be changed, how would you like them to change?

- | | |
|--|--|
| <input type="checkbox"/> Straighten the front teeth – upper / lower | <input type="checkbox"/> Eliminate crowding of teeth – upper / lower |
| <input type="checkbox"/> Straighten the back teeth – upper / lower | <input type="checkbox"/> Eliminate spaces between teeth – upper / lower |
| <input type="checkbox"/> Move upper teeth – forward / backward | <input type="checkbox"/> Make the line of the upper teeth more level |
| <input type="checkbox"/> Move lower teeth – forward / backward | <input type="checkbox"/> Other _____ |

Face – If your facial appearance could be changed, what would you change?

- | | |
|--|---|
| <input type="checkbox"/> Move upper lip – forward / backward | <input type="checkbox"/> Make my nose - longer / shorter |
| <input type="checkbox"/> Move lower lip – forward / backward | <input type="checkbox"/> Get rid of sag under lower jaw |
| <input type="checkbox"/> Show – more / less – teeth when I smile | <input type="checkbox"/> Move chin – forward / backward |
| <input type="checkbox"/> Show – more / less – gums when I smile | <input type="checkbox"/> Move chin – left / right |
| <input type="checkbox"/> Reduce the strain in my – chin / lips – when I close my lips | <input type="checkbox"/> Other: _____ |

Make my lips – **closer together / farther apart** – when my teeth are touching

Symptoms – If you want to reduce pain or discomfort, please be specific about its location; circle right or left side of both if they apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> In front of my ears – right / left | <input type="checkbox"/> My temples – right / left | <input type="checkbox"/> My jaw joints – right / left |
| <input type="checkbox"/> Below ears – right / left | <input type="checkbox"/> My eyes – right / left | <input type="checkbox"/> My teeth |
| <input type="checkbox"/> Above ears – right / left | <input type="checkbox"/> My neck – right / left | <input type="checkbox"/> My sinuses |
| <input type="checkbox"/> In my ears – right / left | <input type="checkbox"/> My shoulders – right / left | <input type="checkbox"/> Other _____ |

**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record or medical or dental status, I will inform the practice. In addition, I authorize Dr. Ritucci to perform a complete orthodontic examination.

Signature of Patient _____

Date _____

Update Signature _____

Date _____

Update Signature _____

Date _____