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_____Cell 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 _____Cell Phone_____

Financial Responsible Party Information

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

Name _____
Last First Middle

Residence _____ ☐ Own ☐ Rent
Street City State Zip

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 _____

Travel History

Have you or any member of your immediate family traveled outside of the United States recently? No____ Yes ____.

If yes, please specify when and where: _____

Cell Phone Use Policy

1, ☐ I provide consent to the office of Robert A. Ritucci, D.M.D., P.C. to use my cell phone number to (choose one or both)

☐ call or ☐ text regarding appointments.

2. ☐ I consent to the office of Robert A. Ritucci, D.M.D., P.C. to call using my cell phone regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time. My cell phone number is _____.

Please initial: _____

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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 Nickel?
Y N Penicillin or other antibiotics?
Y N Sulfa drugs?
Y N Aspirin, Ibuprofen, Tylenol?
Y N Local anesthetics?
Y N Codeine or other narcotics?
Y N Other? _____
Y N Respiratory problems, emphysema?
Y N Asthma, hay fever, sinus trouble, hives?
Y N Persistent swollen neck glands?
Y N Thyroid or endocrine problems?
Y N Diabetes?
Y N Hepatitis, jaundice or liver disease?
Y N AIDS or HIV infection?
Y N Sexually transmitted disease?
Y N Substance abuse problem (past or present)?
Y N Mental health or behavioral problems?
Y N Fainting spells or seizures?
Y N Epilepsy or other neurological disease?
Y N Problems with the immune system?
Y N Abnormal bleeding on blood transfusion?
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 _____

Y N High or low blood pressure?
Y N Have you ever taken a Bis-phosphonate drug?
Y N Have you ever taken the drug Phen-Fen?
Y N Cardiovascular disease (heart trouble, attack angina, arteriosclerosis, stroke)
Y N Damaged or artificial heart valves, including heart murmur of rheumatic heart disease?
Y N Cardiac pacemaker?
Y N Require pre-medication before dental visits?
Y N Arthritis or joint problems or artificial joints/limbs?
Y N Bone disorder, fractures or trauma to face or jaw?
Y N Kidney trouble?
Y N Birth defects or hereditary problems?
Y N Vision, hearing, tasting or speech difficulty?
Y N Tuberculosis, mono, polio, pneumonia?
Y N Persistent cough greater than 3 weeks duration?
Y N Cough that produces blood?
Y N Frequent headaches, colds or sore throats?
Y N Stomach ulcer or hyperacidity?
Y N Skin problems?
Y N Tumor or growth (cancerous or benign)?
Y N Radiation therapy or Chemotherapy?
Y N **Females:** Are you pregnant?
Y N Are you taking birth control pills?

_____

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
Y	N	Have you been treated for "TMJ"?			of your face or around ears?
Y	N	Do you grind your teeth?	Y	N	Do you notice clicking or popping in your jaw
Y	N	Do you clench your teeth?			joint or ringing in the ears?
Y	N	Has your jaw ever locked?	Y	N	Do you have difficulty chewing or opening
Y	N	Does your bite feel uncomfortable or unusual?			your mouth?

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?

- ☐ Straighten the front teeth – **upper / lower**
- ☐ Straighten the back teeth – **upper / lower**
- ☐Move upper teeth – **forward / backward**
- ☐ Move lower teeth – **forward / backward**
- ☐ Eliminate crowding of teeth – **upper / lower**
- ☐ Eliminate spaces between teeth – **upper / lower**
- ☐ Make the line of the upper teeth more level
- ☐ Other _____

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

- ☐ Move upper lip – **forward / backward**
- ☐ Move lower lip – **forward / backward**
- ☐ Show – **more / less** – teeth when I smile
- ☐ Show – **more / less** – gums when I smile
- ☐ Reduce the strain in my – **chin / lips** – when I close my lips
- ☐ Make my lips – **closer together / farther apart** – when my teeth are touching
- ☐ Make my nose - **longer / shorter**
- ☐ Get rid of sag under lower jaw
- ☐ Move chin – **forward / backward**
- ☐ Move chin – **left / right**
- ☐ Other:_____

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.

- ☐ In front of my ears – **right / left**
- ☐ Below ears – **right / left**
- ☐ Above ears – **right / left**
- ☐ In my ears – **right / left**
- ☐ My temples – **right / left**
- ☐ My eyes – **right / left**
- ☐ My neck – **right / left**
- ☐ My shoulders – **right / left**
- ☐ My jaw joints – **right / left**
- ☐ My teeth
- ☐ My sinuses
- ☐ 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