Robert A. Ritucci, D.M.D.

Specialist in Orthodontics
For
Children, Adolescents & Adults

Patient Information

Date _____

Patient's Name _____
Last First Middle

Home Address _____
Street City State Zip

E-Mail _____

Nickname _____ Birthday _____ Age _____ Sex _____ Home Phone _____

If patient is a minor, give parent or guardian's name _____

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

Responsible Party Information

Who is financially responsible for the account? Mother _____ Father _____ Both _____ Other _____

Mother _____
Last First Middle Marital Status

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address _____ How long at this address? _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail Address _____

Social Security # _____ Birthday _____

Employer _____ Occupation _____ No. of years Employed _____

Parents are: Married _____ Widowed _____ Separated _____ Divorced _____

If divorced, who is the custodial parent? Mother _____ Father _____ Both _____

Father _____
Last First Middle Marital Status

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address _____ How long at this address? _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail Address _____

Social Security # _____ Birthday _____

Employer _____ Occupation _____ No. of years Employed _____

Dental Insurance Information

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

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

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

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: _____

Additional HIPAA Authorization

The office of Robert A. Ritucci, D.M.D., P.C. may release health information to the following people:

Name _____ Relationship to patient _____ Date Authorized _____

Name _____ Relationship to patient _____ Date Authorized _____

Emergency Information

Name of nearest relative not living with you _____

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: _____

Robert A. Ritucci, D.M.D.

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Child / Adolescent 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 Is the patient in excellent health?

Patient's last physical exam was _____ (month/year). Physician name / phone: _____

Y N Has there been any change in the patient's general health within the last year?

Y N Is the patient now under the care of a physician? If so, what is being treated? _____

Y N Has the patient had a serious illness/hospitalization in the past 5 years? If so, for what? _____

Y N Is the patient taking any medication (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 Skin disorder?
Y N Persistent swollen neck glands?
Y N Thyroid or endocrine problems?
Y N Diabetes?
Y N Hepatitis, jaundice or liver disease?
Y N Problems with the immune system?
Y N AIDS or HIV infection?
Y N Sexually transmitted disease?
Y N Substance abuse problem (past or present)?
Y N Mental health problem or behavioral problems?
Y N Fainting spells or seizures?
Y N Epilepsy or other neurological disease?
Y N Blood disorder such as anemia, leukemia, hemophilia?
Y N Abnormal bleeding or blood transfusion?
Y N Does the patient 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 Inborn heart defects?
Y N Cardiac pacemaker?
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 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 Birth defects or hereditary problems?
Y N Kidney trouble?
Y N Vision, hearing, tasting or speech difficulty?
Y N Tuberculosis, mono, polio, pneumonia?
Y N Persistent cough greater than 3 weeks?
Y N Cough that produces blood?
Y N Frequent headaches, colds or sore throats?
Y N Tumor (cancerous or benign)?
Y N Stomach ulcer or hyperacidity?
Y N Radiation therapy or Chemotherapy?
Y N Tonsils or adenoids removed? What age? _____
Y N Is the patient's height and weight normal for age?
Y N Do you snore?
Y N Do you have sleep apnea?
Y N Do you have sleep disorder breathing?

Dental History

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

Y	N	Chipped or injured permanent 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 examination?
Y	N	Current or previous 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	Loose or shifting teeth?
Y	N	Mouth breathing habit or snoring troubles?	Y	N	Thumb, finger or sucking habit as a child?
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	Is the patient's diet high in sweets/sugars?
Y	N	Realizing that successful treatment depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment?	Y	N	Is child taking any forms of fluoride?

Patient's deciduous (baby) teeth came in ☐ EARLY ☐ AVERAGE ☐ LATE

Patient's deciduous (baby) teeth were lost ☐ EARLY ☐ AVERAGE ☐ LATE

Patient's mouth most resembles ☐ MOTHER ☐ FATHER ☐ BOTH ☐ NEITHER

Has another family member received orthodontic care? Y N Who? _____

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 grind your teeth?	Y	N	Do you notice clicking or popping in your jaw joint or ringing in the ears?
Y	N	Do you clench your teeth?			
Y	N	Has your jaw ever locked?	Y	N	Do you have difficulty chewing or opening your mouth?
Y	N	Does your bite feel uncomfortable or unusual?			

Reasons For Seeking 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 to this history record or medical or dental status, I will inform the practice. In addition, I authorize Dr. Ritucci to do a complete orthodontic examination.

_____ Date
Signature of Parent (or Guardian)

_____ _____
Update Signature Date

_____ _____
Update Signature Date