RISINGER ORTHODONTICS

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Patient Information

Patient's Name _____

Prefers to be called

PATIENT INFORMATION

FIRST& LAST NAME: BIRTHDATE: AGE:

MAILING ADDRESS: HOME PHONE:

PHONE (H): _____

(W): _____

(C): _____

E-MAIL: _____
By providing us with your e-mail address you will be allowed 24 hour access to our website to view appointments, account information, patient photographs and x-rays and receive email appointment reminders.

HOW DID YOU HEAR ABOUT US?

- ☐ GENERAL DENTIST
- ☐ YELLOW PAGES
- ☐ INTERNET SEARCH
- ☐ PATIENT/FRIEND
  name: _____
- ☐ OTHER:
  _____

EMPLOYER: _____ SSN: _____

NAME OF GENERAL DENTIST: _____ DATE OF LAST VISIT: _____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY(if different than spouse/partner):

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER(S): HOME: _____ CELL: _____

MARITAL STATUS: Single☐ Married☐ Partners☐ Divorced☐ Separated☐ Widow(er)☐

SPOUSE/PARTNER'S NAME: _____
ADDRESS (if different from patient):

_____
STREET ADDRESS

_____
CITY, STATE, ZIPCODE

PHONE (H): _____

(W): _____

(C): _____

E-MAIL: _____
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EMPLOYER: _____

SSN: _____

CHILDREN:

NAME	BIRTHDATE	GENDER
_____	____/____/____	M / F
_____	____/____/____	M / F
_____	____/____/____	M / F
_____	____/____/____	M / F
_____	____/____/____	M / F

IF THE PERSON RESPONSIBLE FOR THIS ACCOUNT DIFFERS FROM ABOVE:

NAME: _____ RELATIONSHIP TO PATIENT: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE (H): _____ (W): _____ (C): _____

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Patient Information

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MEDICAL HISTORY

Please check Yes or No if you have or have had:

Yes	No		Yes	No	
☐	☐	Adenoids removed	☐	☐	Joint Swelling
☐	☐	Anemia	☐	☐	Kidney or Liver Involvement
☐	☐	Arthritis	☐	☐	Latex Allergy
☐	☐	Bone disorders	☐	☐	Mitral Valve Prolapse
☐	☐	Cancer	☐	☐	Prolonged bleeding
☐	☐	Diabetes	☐	☐	Rheumatic trouble
☐	☐	Emotional Problems	☐	☐	Smoked
☐	☐	Epilepsy	☐	☐	Sore throats
☐	☐	Fainting/ Dizziness	☐	☐	Thyroid problems
☐	☐	Heart Trouble	☐	☐	Tonsillitis
☐	☐	High Blood pressure	☐	☐	Tonsils removed
☐	☐	Joint prosthesis	☐	☐	Tuberculosis
☐	☐	Do you need antibiotic premedication prior to dental cleanings?			
☐	☐	Have you ever taken any bisphosphonate medications? (Ex. Fosamax, Actonel, Boniva, Aredia, or Zometa)			

On items checked "YES", please provide us with a more detailed description:

HAVE YOU OR ANY MEMBER OF YOUR FAMILY OR CLOSE RELATIVES HAD: Rheumatoid Arthritis? Yes ☐ No ☐
Lupus? Yes ☐ No ☐

NAME OF PRIMARY CARE PHYSICIAN: (Name and Town/City)

_____

LIST ANY SERIOUS ILLNESSES:

_____

_____

LIST ANY ALLERGIES:

_____

_____

LIST DRUGS OR MEDICATIONS CURRENTLY BEING TAKEN:

_____

_____

ARE YOU PRESENTLY UNDER PHYSICIAN 'S CARE? Yes ☐ No ☐

REASON: _____

_____

IF FEMALE, IS THERE A POSSIBILITY YOU ARE PREGNANT?
Yes ☐ No ☐ If yes, how many weeks? _____

DENTAL HISTORY

Please check Yes or No:

Yes	No	
☐	☐	Any injuries to face, mouth, teeth?
☐	☐	Thumb, finger, lip sucking?
☐	☐	More than average amount of decay?
☐	☐	Any missing permanent teeth?
☐	☐	Any extra permanent teeth?
☐	☐	Any teeth removed by extraction?
☐	☐	Any difficulty in swallowing or chewing?
☐	☐	Any pain or clicking on opening mouth?
☐	☐	Do you visit dentist regularly? Date of last dental visit? _____
☐	☐	Do your gums ever bleed?
☐	☐	Have you ever experienced pain or discomfort in your jaw joint (TMJ)?
☐	☐	Do you like to smile?

On items checked "YES", please provide us with a more detailed description:

PATIENTS ATTITUDE TOWARD ORTHODONTIC TREATMENT

(circle one): very motivated will cooperate if needed not motivated

WHAT IS THE MOST IMPORTANT THING FOR US TO ADDRESS AT TODAY'S VISIT?

_____

_____

_____

HAVE YOU EVER HAD OR BEEN EVALUATED OR HAD ORTHODONTIC TREATMENT? Yes ☐ No ☐

If yes, when? _____

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

_____ Date

_____ Signature of Patient