Joseph W. Restic, D.M.D.,LLC
Orthodontic Specialist for Children and Adults

Patient Information

Patient's Name _____ _____ _____ _____
FIRST MIDDLE LAST SEX BIRTHDATE AGE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell Phone _____ Email Address _____

Parent/Guardian Name _____ Patient lives with _____

Dentist _____ Family Physician _____ Referred by _____

School _____ Grade _____ Hobbies/Interests _____

What are your orthodontic concerns? _____

Medical History

Does Patient have a history of the following:

YES	NO		YES	NO		YES	NO	
❑	❑	Anemia	❑	❑	Heart Disease or Murmur	❑	❑	Frequent Colds or Flu
❑	❑	Blood Disease	❑	❑	Tuberculosis	❑	❑	Tonsillitis
❑	❑	Hepatitis	❑	❑	Endocrine Problems	❑	❑	Tonsils Removed: Age: _____
❑	❑	AIDS or HIV positive	❑	❑	Bone Disorders	❑	❑	Adenoids Removed: Age: _____
❑	❑	Jaundice	❑	❑	Epilepsy	❑	❑	Asthma
❑	❑	Rheumatic Fever	❑	❑	Herpes / Venereal Disease	❑	❑	Prolonged Bleeding
❑	❑	Malignancies, Tumors, or Cancer	❑	❑	Emotional Stress	❑	❑	Oral Bisphosphonate Use

Is the patient in good health? ❑ YES ❑ NO Reason: _____

Any major or unusual illnesses? ❑ YES ❑ NO Explain: _____

Currently under physician's care? ❑ YES ❑ NO Reason: _____

Currently taking medication? ❑ YES ❑ NO List: _____

Allergies? ❑ YES ❑ NO List: _____

Drug sensitivity? ❑ YES ❑ NO List: _____

NOTES: _____

Dental History

Does Patient have a history of the following:

YES	NO		YES	NO		YES	NO	
❑	❑	Jaw Joint Popping	❑	❑	Snoring Loudly	❑	❑	Grinding Teeth
❑	❑	Ringing in the Ears	❑	❑	High Decay Rate	❑	❑	Headaches (more than normal)
❑	❑	Jaw Joint Clicking	❑	❑	Mouth Breather	❑	❑	Speech Problems or Speech Therapy
❑	❑	Tongue Thrust	❑	❑	Hard Blow to Chin	❑	❑	Muscular Soreness around Head & Neck
❑	❑	Jaw Joint Soreness	❑	❑	Clenching Teeth			

❑ ❑ Has the patient had any severe head or face injuries? Explain: _____

❑ ❑ Has the patient had a history of thumb or finger sucking? Stopped? _____

❑ ❑ Does the patient play any musical (wind) instruments? What? _____

❑ ❑ Has the patient consulted an orthodontist previously? _____

❑ ❑ Has the patient had any previous orthodontic treatment? Explain: _____

NOTES: _____

I have completed the patient information and medical/dental section to the best of my knowledge and have not withheld any information that may affect either myself or the dental staff during treatment.

Signature (Parent's signature if minor) _____ Date: _____

Growth Information (For Patients under 16 years of age)

Father's Height: _____ Mother's Height: _____ Patient's Height: _____ Adopted? ❑ Yes ❑ No

Patient Resembles: ❑ Neither Parent ❑ Both Parents ❑ Mother ❑ Father

Girls: Has she started menstruation? ❑ No ❑ Yes When? _____

Boys: Has his voice changed? ❑ No ❑ Yes When? _____

Names and Ages of Patient's Brothers and Sisters: _____

Have any had Orthodontic Treatment? ❑ No ❑ Yes When? _____

Please Complete Reverse Side

Responsible Party Information

Name _____ Relationship to Patient _____
FIRST MIDDLE LAST

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

2nd Resp. Party Name _____ Relationship to Patient _____
FIRST MIDDLE LAST

Address _____
STREET CITY STATE ZIP

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Dental/Orthodontic Insurance Information

PRIMARY

Subscriber Name _____ Insured DOB _____

Insured's Soc. Sec. No. / or ID # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ins. Co. Phone _____

SECONDARY

Subscriber Name _____ Insured DOB _____

Insured's Soc. Sec. No. / or ID # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ins. Co. Phone _____

Teeth Present R _____ L R _____ L

Angle Class Rt Lt Division I II **Cuspid** Rt Lt

OB % **Openbite** mm **OJ** mm end to end

Crowding/Spacing Mandible mm Maxilla mm

X-Bite R _____ L Missing/ Malformed R _____ L Impacted/ TSD R _____ L

Midlines R _____ L Coincident At Rest R _____ L

Dental Development Early Late WNL **Habits** Finger Thumb Stopped No

Frenum/Diastema Mandible mm Maxilla mm

Hygiene Excellent Good Fair Poor

Initial TMJ Palpation Tenderness WNL
Sounds Click Pop Crepitis Rt Lt WNL Opening Closing

Disposition Recall 3 6 12____ Months
Records Full Photo's Models Mounted Pan Ceph BW PA
Records _____date Recall_____ date Pt to call Dismiss

Summary