Metropolitan Dental Centers

ORTHODONTIC REGISTRATION

PATIENT'S LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
SEX □ MALE □ FEMALE	FULL TIME STUDENT □ YES □ NO	SOCIAL SECURITY NO.	
NEAREST RELATIVE OR FRIEND'S NAME , ADDRESS & PHONE (not at same address) □ RELATIVE □ FRIEND			

Dentist _____

Address _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

PRIMARY BILLING PARTY LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
EMAIL ADDRESS	SOCIAL SECURITY NO / DRIVERS LICENSE NO.		WORK PHONE
EMPLOYED BY	MARITAL STATUS □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED		CELL PHONE
BUSINESS ADDRESS	HOW LONG EMPLOYED □ HOURLY □ SALARY □ RETIRED		

PRIMARY DENTAL INSURANCE CO.		MAILING ADDRESS	
GROUP #	SERVICE CODE	CONTRACT ID/ S.S. NO.	INS. CO. PHONE NO.

SECOND BILLING PARTY LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
EMAIL ADDRESS	SOCIAL SECURITY NO / DRIVERS LICENSE NO.		WORK PHONE
EMPLOYED BY	MARITAL STATUS □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED		CELL PHONE
BUSINESS ADDRESS	HOW LONG EMPLOYED □ HOURLY □ SALARY □ RETIRED		

SECONDARY DENTAL INSURANCE CO.		MAILING ADDRESS	
GROUP #	SERVICE CODE	CONTRACT ID/ S.S. NO.	INS. CO. PHONE NO.

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year?
3. YES NO Have you been hospitalized or had a serious illness in the last three years?
   If YES, explain? _____
4. YES NO Are you being treated by a physician now? For what? _____
   Physician's Name and Phone No. _____
5. YES NO Have you had problems with prior dental treatment? If YES, please explain _____
   Date of last Dental Exam _____
6. YES NO Any prior orthodontic treatment (retainers, braces, expander,etc.)
   If so, when & where? _____

II. DO YOU HAVE OR HAVE YOU HAD: (If yes, please indicate by circling appropriate answer)

7. YES NO Heart problems? If so, what? _____
   If YES on any of the above: Treating Physician's Name & Phone No. _____
8. YES NO Rheumatic fever?
9. YES NO Stroke, hardening of arteries?
10. YES NO High blood pressure?
11. YES NO Asthma, TB, emphysema, other lung disease?
12. YES NO Hepatitis, other liver disease?
13. YES NO Family history of diabetes, heart problems?
14. YES NO Psychiatric care?
15. YES NO Radiation treatments?
16. YES NO Chemotherapy?
17. YES NO Artificial joint?
18. YES NO Tumors, cancer?
19. YES NO Arthritis, rheumatism?
20. YES NO Jaw popping, clicking, or difficulty opening
21. YES NO Snoring?
22. YES NO Frequent Sore Throat?
23. YES NO Allergies: **food, medications, latex, nickel**?
    If YES please explain: _____
    List medications taken: _____
24. YES NO Anemia?
25. YES NO VD (syphilis/gonorrhea)?
26. YES NO Herpes?
27. YES NO Kidney, bladder disease?
28. YES NO Thyroid, adrenal disease?
29. YES NO Diabetes?
30. YES NO HIV/AIDS?
31. YES NO Hospitalization?
32. YES NO Blood transfusions?
33. YES NO Osteoporosis?
34. YES NO Pacemaker?
35. YES NO Surgeries?
36. YES NO Headaches?
37. YES NO Sleep with mouth open?
38. YES NO Tonsils/Adenoids Removed
39. YES NO Seasonal Allergies:
    If YES please explain: _____
    List medications taken: _____

III. ARE YOU TAKING:

40. YES NO Recreational drugs?
41. YES NO Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?
42. YES NO Tobacco in any forms?
    If Yes, how much _____
43. YES NO Alcohol?
    If Yes, how often _____

Please list: _____

_____

IV. WOMEN ONLY:

44. YES NO Are you or could you be pregnant or nursing?
45. YES NO Taking birth control pills?

V. ALL PATIENTS:

46. YES NO Do you or have you had any other diseases or medical problems NOT listed on this form?
    If Yes, please explain: _____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature: _____ Date: _____

HEADACHE AND FACIAL PAIN SCREENING QUESTIONNAIRE

Name: _____ **Date:** _____

Temporomandibular Disorders are a frequent cause of headaches, facial pain and dental pain.
Please complete this screening questionnaire.

SYMPTOM CHECKLIST: Please check any of the following symptoms that apply to you. (L=left and R=right)

Headaches:

_____ Migraines _____ Tension Headaches _____ Other _____

How often? _____

Top of Head	_____ L	_____ R		Temples	_____ L	_____ R	
Forehead	_____ L	_____ R		Behind Eyes	_____ L	_____ R	
Back of Head	_____ L	_____ R		Pain in Shoulder	_____ L	_____ R	
Pain in Head	_____ L	_____ R		Ear Congestion	_____ L	_____ R	
Pain in Ear	_____ L	_____ R		Tinnitus (ringing in ears)	_____ L	_____ R	
Dizziness (vertigo)	_____ L	_____ R		Facial Pain (non-specific)	_____ L	_____ R	
Pain in Jaw Joint	_____ L	_____ R		Grating sound in joint	_____ L	_____ R	

Clicking or popping in jaw joint _____ L _____ R

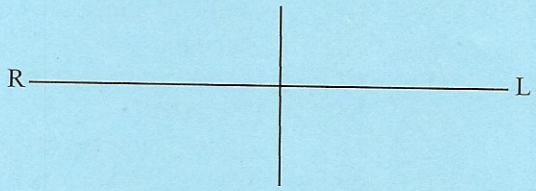
Partial inability to open mouth _____ No _____ Yes _____ Constant _____ Sporadic

Face muscle twitch _____ No _____ Yes

Difficulty swallowing _____ No _____ Yes

Difficulty breathing through nose _____ No _____ Yes

Difficulty chewing _____ No _____ Yes



Have you ever worn braces _____ No _____ Yes

Age when braces were on _____

Orthodontist _____

SLEEP APNEA EVALUATION

We have seen a recent increase of sleep apnea findings in our patients, which is a life threatening medical problem. To protect your health, we are asking you to complete the following screening form.

PLEASE ANSWER:

Do you snore? _____ No _____ Yes

$$BMI = \frac{W}{H^2\ (in)} \times 703 = \_\_\_\_\_$$

Are you excessively tired during the day? _____ No _____ Yes

Have you been told you stop breathing during sleep? _____ No _____ Yes

Do you have a history of hypertension? _____ No _____ Yes

Is your neck size greater than…….
17 inches (male)
16 inches (female) _____ No _____ Yes

YES to two or more of these questions is a positive screen for sleep apnea. If you answered yes to two or more questions, show this completed questionnaire to your doctor.