Center for Early Orthodontic Treatment

WELCOME!

Thank you for choosing our Center for your orthodontic care!

PATIENT INFORMATION

Patient's Name:_____ **DOB:**_____ **Age:** _____ **Gender:** ☐ M ☐ F

Preferred Name:_____ **SS#:**_____

Street Address:_____ **City:**_____ **State:** _____ **Zip:**_____

Primary number for appointment confirmations: (____) ____ - _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home: (____) ____ - _____ **Cell:** (____) ____ - _____ **Work:** (____) ____ - _____

Email:_____

Employer:_____ **Employer's Address:**_____

Occupation:_____ **How long there?**_____

Person responsible for account:_____

Name of nearby relative or friend:_____ **Relationship to patient:**_____

Home: (____) ____ - _____ **Cell:** (____) ____ - _____

Other family members seen by us:_____

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured:_____

DOB:_____ **SS#:**_____

Employer: _____

Phone: (____) ____ - _____

Insurance Co.:_____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: (____) ____ - _____

Group/Policy #:_____

I.D.#:_____

SECONDARY COVERAGE

Name of Insured:_____

DOB:_____ **SS#:**_____

Employer:_____

Phone: (____) ____ - _____

Insurance Co.:_____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: (____) ____ - _____

Group/Policy #:_____

I.D.#:_____

HOW DID YOU HEAR ABOUT US?

☐ **Friend:**_____

☐ **Physician**:_____

☐ **Dentist:**_____

☐ **Insurance:**_____

☐ **Other:**_____

☐ **Drive by** ☐ **Website** ☐ **Facebook** ☐ **Google**

DENTAL HISTORY

General Dentist:_____ **Phone:** (____) ____ - _____ **Date of Last Exam:**_____

Main concerns you would like Orthodontics to address?_____

Please check all that applies to you:

- ☐ Any injuries to the head or neck area
- ☐ Any injuries to the mouth or teeth
- ☐ Snoring
- ☐ Breathe through mouth more than nose
- ☐ Frequent colds, sore throats, or ear infections
- ☐ Morning headaches
- ☐ Pain and / or clicking in jaw joint
- ☐ Jaw has ever "locked" open or closed
- ☐ Grind or clench your teeth
- ☐ Adult teeth came in behind baby teeth
- ☐ Teeth removed by a Dentist
- ☐ Difficulty chewing and / or swallowing
- ☐ Noisy eating
- ☐ Speech Problems
- ☐ Sucking habits (thumb, finger, lip, etc.)
- ☐ Biting/Chewing habits (tongue, cheek, nails)
- ☐ Bottlefed / Breastfed
- ☐ Pacifier use
- ☐ Previous orthodontic evaluation
- ☐ Previous orthodontic treatment
- ☐ Unusual dental experience

Please specify**:**_____

_____

MEDICAL HISTORY

Physician's Name:_____ **Phone:** (____) ____-____ **Date of Last Exam:**_____

History of Hospitalizations / Surgeries / Recent Illnesses (explain):_____

Are you currently under the care of any health practitioner (MD, Osteopath, Chiropractor, Physical Therapist, etc.) ☐ Yes ☐ No

Please explain: _____

Current Medications:_____

Have you had tonsils and/or adenoids removed? ☐ Yes ☐ No **If Yes, when?** _____

Have you ever been diagnosed and/or treated for any of the following conditions? (check all that apply)

- ☐ Blood Disorder / Anemia
- ☐ Abnormal Bleeding / Hemophilia
- ☐ Immune Disorder / HIV/AIDS
- ☐ Cancer / Tumor / Leukemia
- ☐ Heart Murmur / Defect / Surgery
- ☐ Rheumatic Fever
- ☐ High / Low Blood Pressure
- ☐ Heart Attack / Stroke
- ☐ Kidney Problems
- ☐ Liver Disease / Jaundice / Hepatitis
- ☐ Diabetes
- ☐ Stomach / GI Disorder
- ☐ Tuberculosis (TB)
- ☐ Asthma / Reactive Airway
- ☐ Tonsillitis
- ☐ Sinus Infection
- ☐ Cold Sores
- ☐ Tendency to Colds
- ☐ Eating Disorder
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Frequent Headaches
- ☐ Drug / Alcohol Abuse
- ☐ Epilepsy / Seizures / Convulsions
- ☐ ADD / ADHD
- ☐ Psychiatric / Emotional Problems

ALLERGIES:

- ☐ Drugs:_____
- ☐ Dairy Products ☐ Metal/Plastic
- ☐ Wheat/Cereal ☐ Latex
- ☐ Food Dyes ☐ Dust, Pollen
- ☐ Other: _____

I affirm that the above information is true and correct to the best of my knowledge. I hereby, give my permission to Dr. Pinskaya to communicate with other healthcare professionals regarding treatment recommended.

Patient's Signature:_____ **Date:**_____

9595 Angola Court Indianapolis IN 46268 P (317) 672-3530 F (317) 672-3532