Troy Orthodontics, PC

Beth A. Troy, DMD, MS
Eric J. Reitz, DMD, MDS
Gary J. Yanniello, DMD

PATIENT INFORMATION: (Please Print) Appt Date_____

Patient Name _____Nickname _____
Gender_____ Birthdate_____/_____/_____ Age_____
Street Address_____
City/State/Zipcode _____
Home phone#_____ Cell phone#_____
Email _____
Emergency contact person and phone_____
Dentist _____
Dentist Address_____
Referred by _____

PERSON(S) RESPONSIBLE FOR ACCOUNT:
Name (Mr./Mrs./Ms. circle one)_____
Street Address _____
City/State/Zipcode _____
Home Phone# _____ Cell Phone#_____
Email _____
Place of Employment _____ Work#_____

PRIMARY DENTAL INSURANCE: (Must be provided to submit to insurance)
Ins. Co. name & address_____
Is this a CHIP/Medical Assistance Program? (circle) Yes No (circle) PPO or DMO
Subscriber name _____Birthdate_____
Subscriber social security# _____ or ID#_____
Group# _____ Place of Employment_____

SECONDARY DENTAL INSURANCE (if any):
Ins. Co. name & address_____
Is this a CHIP/Medical Assistance Program? (circle) Yes No (circle) PPO or DMO
Subscriber name _____Birthdate_____
Subscriber social security# _____ or ID#_____
Group# _____ Place of Employment_____

PATIENT DENTAL HISTORY:
When was your last visit to the dentist?_____
Have you had previous orthodontic treatment?_____ If yes, when?_____
Have you ever had injuries to the face or teeth?_____ If yes, when?_____
What type of injury?_____
Have you ever or do you have a finger/thumb sucking habit? _____
How often do you brush? _____ How often do you floss?_____

Please check the appropriate box below if you have/had any of the following:

	Yes	No		Yes	No
Bad breath	☐	☐	Lip/cheek biting	☐	☐
Bleeding gums	☐	☐	Loose teeth/broken fillings	☐	☐
Blisters on lips/mouth	☐	☐	Mouth breathing	☐	☐
Burning sensation on tongue	☐	☐	Mouth pain during brushing	☐	☐
Cigarette/pipe/cigar smoking	☐	☐	Pain around ear	☐	☐
Dry mouth	☐	☐	Periodontal (“gum”) treatment	☐	☐
Fingernail biting	☐	☐	Sensitivity to cold	☐	☐
Food collection betw. teeth	☐	☐	Sensitivity to heat	☐	☐
Gag reflex	☐	☐	Sensitivity to sweets	☐	☐
Grinding teeth	☐	☐	Sensitivity when biting	☐	☐
Gums swollen or tender	☐	☐	Sores/growths in mouth	☐	☐
Jaw pain/tiredness ("TMJ")	☐	☐			

PATIENT HEALTH HISTORY:

Primary Care Physician and phone_____

Have you ever had any serious illnesses or surgeries?_____ If yes, please describe:

_____

Please list allergies, including dental anesthetics_____

Please list any medications you are taking_____

Are you taking or have you ever taken medication for bone density? _____

Is there any other information you feel we should know to help better care for you or your child?

_____

Please check the appropriate box below if you have/had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Diabetes	☐	☐	Mitral valve prolapse	☐	☐
ADD/ADHD	☐	☐	Emphysema	☐	☐	Nervousness	☐	☐
Asperger's/Autism	☐	☐	Epilepsy	☐	☐	Pacemaker	☐	☐
Anemia	☐	☐	Fainting/dizziness	☐	☐	Radiation treatment	☐	☐
Arthritis/rheumatism	☐	☐	Headaches	☐	☐	Sinus trouble	☐	☐
Artificial heart valves	☐	☐	Heart Murmur	☐	☐	Skin rash	☐	☐
Artificial joints	☐	☐	Heart Problems	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Hepatitis type___	☐	☐	Swollen feet/ankles	☐	☐
Bleeding/blood disease	☐	☐	High Blood Press.	☐	☐	Swollen neck glands	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Thyroid problems	☐	☐
Chemotherapy	☐	☐	Liver Disease	☐	☐	Tonsillitis	☐	☐
Cong. heart lesions	☐	☐	Low Blood Press.	☐	☐	Vertigo	☐	☐
Cortisone treatments	☐	☐						

AUTHORIZATION:

I have completed the above dental/medical histories to the best of my knowledge. I authorize my insurance company to pay the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the release of all information necessary to secure payment of benefits. I authorize that I am financially responsible for all charges whether or not paid by insurance. I have received a copy/been advised of the HIPAA Notice of Privacy Practices.

_____ _____

Patient Signature or Parent/Guardian Date

I have reviewed the above medical and dental history. The treatment plan, treatment options, and potential complications have been reviewed with the patient and/or parent(s)/guardian(s).

_____ _____

Doctor signature Date

Updates: To be filled in at future appointments

Have you had any changes in your medical history? Yes or No (please circle)
If yes, please indicate changes: ______________________________
____
Patient signature: ______________________ Date: ______________

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If yes, please indicate changes: ______________________________
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Patient signature: ______________________ Date: ______________

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