James A. Tetz D.M.D., Inc

Specialist in Orthodontics for Children, Youth & Adults

ORTHODONTIC PATIENT INFORMATION

First Name_____ Middle_____ Last_____ Nickname_____

Patient Address_____
City Zip

Patient Home Phone_____

Patient's Date of Birth_____ Age_____ Gender_____

Patient's Dentist_____ Date of last visit_____ City of Dentist: _____

Referred by_____ Patient's physician_____ City of Physician_____

Please explain reasons for seeking orthodontic care_____

School_____ Grade/Year_____

Patient's interest and hobbies_____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE PARENT/GUARDIAN INFO:

Patient lives with (parents, mother, father, guardian, etc…) _____

***Mother/Step-mother/(circle) Name**_____

Address if different from patient_____

Cell_____ Email Address_____

Work place_____ Occupation_____

***Father/Step-father/(circle) Name**_____

Address if different from patient_____

Cell_____ Email Address_____

Work place_____ Occupation_____

***Guardian or other step-parent/ (circle) Name**_____

Address if different from patient_____

Cell_____ Email Address_____

Work place_____ Occupation_____

***Is there a custodial parent by court order? If yes, Name**_____

Relationship to patient_____

IF THE PATIENT IS AN ADULT:

Cell_____ Email Address_____

Workplace_____ Occupation_____

QUESTIONS FOR ALL PATIENTS:

Does anyone in the family have a similar problem? ☐Yes ☐No Describe_____

How would you like your appointments confirmed? ☐ Cell ☐ Home phone ☐ Text ☐ Email

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Patient Name_____ Date_____

JAW JOINT (TMJ) HISTORY

1. Does the patient now have, or has the patient ever had **pain** in the jaw joints or the area of the jaw joints?..... ☐Yes ☐No
2. Does the patient now have, or has the patient ever had pain when **chewing**?.... ☐Yes ☐No
3. Does the patient now have, or has the patient ever had pain when **yawning**?... ☐Yes ☐No
4. Does the patient now have, or has the patient ever had pain when **opening**?..... ☐Yes ☐No
5. Does the patient now have, or has the patient ever had **noise** in the jaw joints?..... ☐Yes ☐No
6. Does the patient now have, or has the patient ever had a **click** in the jaw joints?..... ☐Yes ☐No
7. Does the patient now have, or has the patient ever had a **pop** in the jaw joints?..... ☐Yes ☐No
8. Does the patient now have, or has the patient ever had **difficulty** opening their mouth? ..... ☐Yes ☐No
9. Does the patient now have, or has the patient ever had the jaw become **"stuck"** or **"locked"**?..... ☐Yes ☐No
10. Does the patient **grind** their teeth?..... ☐Yes ☐No

DENTAL HISTORY

1. Does the patient now have, or has the patient ever had any problem with:
   - Sensitive, Sore, or **Bleeding gums** (gingiva)?..... ☐Yes ☐No
   - **Bone loss** around the teeth? ..... ☐Yes ☐No
   - **Recession** of the gum (gingival)?..... ☐Yes ☐No
2. Has the patient ever lost or had **teeth removed**?..... ☐Yes ☐No

Please give teeth and reason:_____

_____

3. **Does** the patient now have a **finger or thumb sucking habit**? ..... ☐Yes ☐No
4. **Did** the patient have a finger or thumb sucking habit? To what age?_____ ..... ☐Yes ☐No

Please circle any **other habits:** Nail biting, lip biting or sucking, mouth breathing, tongue thrusting, teeth clenching, teeth grinding, pencil biting

Other:

5. Does the patient now have, or has the patient ever had difficulty in **swallowing** or **chewing** foods? ..... ☐Yes ☐No
6. Does the patient now have, or has the patient ever had any **speech** problems or speech therapy?..... ☐Yes ☐No

Please describe:_____

_____

7. Does the patient have any **Other** special medical, jaw joint, or dental problems that have not been mentioned above?..... ☐Yes ☐No

2100 East High Street-Suite 105 **Springfield, Ohio 45505** **(937)324-5700**
66 A West High Street **London, Ohio 43140** **(740)852-5050**

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MEDICAL HISTORY

Patient Name_____ Date_____

Patient's Physician_____ City_____

1. Is the patient taking any medication now?..... ☐Yes ☐No
Please list the medications and the purpose of the medication:

_____

2. Does the patient have allergies to medications or anything else?..... ☐Yes ☐No
Please list the allergic items:_____
3. Has the patient ever had any hospitalizations, operations, or major illnesses?..... ☐Yes ☐No
Please date and describe:

_____

4. Does the patient now have, or has the patient ever had frequent headaches?..... ☐Yes ☐No
Please date and describe:

_____

5. Has the patient had any injuries to the face, mouth, teeth or jaws?..... ☐Yes ☐No
Please date and describe:

_____

6. For women: Are you pregnant?..... ☐Yes ☐No

7. Does the patient now have, or has the patient ever had artificial joints placed?..... ☐Yes ☐No

8. Does the patient now have, or has the patient ever had rheumatic fever or rheumatic heart disease?... … ☐Yes ☐No

9. Does the patient now have, or has the patient ever had any heart problems?..... ☐Yes ☐No

10. Does the patient now have, or has the patient ever had a heart murmur?..... ☐Yes ☐No

11. Does the patient now have, or has the patient ever had Tuberculosis? ..... ☐Yes ☐No

12. Does the patient now have, or has the patient ever lived with someone that had Tuberculosis? ..... ☐Yes ☐No

13. Has the patient ever had any problems with the healing of broken bones? ..... ☐Yes ☐No

14. Does the patient now have, or has the patient ever had ear, nose, throat, or sinus problems? ..... ☐Yes ☐No

Please date and describe:_____

15. Has the patient had tonsils or adenoids removed? When? _____..... ☐Yes ☐No

16. Does the patient now have, or has the patient ever had tubes in the ears? ..... ☐Yes ☐No

17. Does the patient now have snoring at night?..... ☐Yes ☐No

18. Is the patient now, or has the patient ever been a mouth breather? (difficulty breathing through the nose)?

..... ☐Yes ☐No

19. Are the patient's lips apart often? ..... ☐Yes ☐No

20. Does the patient currently, or has the patient in the past, use any tobacco products?..... ☐Yes ☐No
(cigarettes, snuff, cigars, chewing tobacco, or pipe) Please state the items: _____

_____

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RESPONSIBLE PARTY INFORMATION

Responsible Party #1

Self_____Spouse_____Mother_____Father_____Other_____

Name_____Phone ( ) _____

Address_____

Employer_____Social Security Number_____

Driver's License #_____Date of Birth_____

Responsible Party #2

Self_____Spouse_____Mother_____Father_____Other_____

Name_____Phone ( ) _____

Address_____

Employer_____Social Security Number_____

Driver's License #_____ Date of Birth_____

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INSURANCE INFORMATION

INSURANCE #1

Is there orthodontic insurance? ☐ YES ☐ NO

Company Name: _____

Company Address: _____Company Phone number:_____

ID Number:_____ Group Number:_____

Subscriber's name:_____ Subscriber's Date of Birth_____

Subscriber's Social Security Number:_____

What is the Lifetime Maximum Amount for Orthodontics? _____

What Percentage is the Lifetime Maximum Benefit Paid Out? _____

Is the Benefit Paid Out Monthly or Quarterly? _____

Is there a deductible? ☐ YES ☐ NO If yes, the deductible amount: _____

INSURANCE #2

Is there orthodontic insurance? ☐ YES ☐ NO

Company Name: _____

Company Address: _____Company Phone number:_____

ID Number:_____ Group Number:_____

Subscriber's name:_____ Subscriber's Date of Birth_____

Subscriber's Social Security Number:_____

What is the Lifetime Maximum Amount for Orthodontics? _____

What Percentage is the Lifetime Maximum Benefit Paid Out? _____

Is the Benefit Paid Out Monthly or Quarterly? _____

Is there a deductible? ☐ YES ☐ NO If yes, the deductible amount: _____