Algirdas S. Vaitas, D.M.D., P.C.

(Please print and fill out completely)

BIRMINGHAM AND MILFORD ORTHODONTIC SPECIALISTS

PATIENT INFORMATION

Today's Date_____ Date of Birth_____ Age_____ SEX: M_____ F _____

Name_____ Nickname_____
(FIRST) (MIDDLE) (LAST)

Address_____ City_____ State _____ Zip_____

Patient Phone(if applicable)_____ Home ☐ *Cell* ☐ Work ☐

Family Dentist_____ City_____ Phone_____

Family Physician_____ City_____ Phone_____

School_____ City_____ Grade_____

Sports/Hobbies, etc._____

RESPONSIBLE PARTY INFORMATION

Name of person responsible for Patient account _____ Relationship _____

Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Father Deceased _____ ☐ Mother Deceased _____

Child lives with: ☐ Both parents ☐Mother ☐ Father ☐ Other/whom: _____

Father's Name: _____ Mother's name:_____

Employer: _____ Employer: _____

Occupation: _____ Occupation: _____

Home address:_____ Home address:_____

Email address: _____ Email address: _____

Father's phone: (home)_____ Mother's phone: (home)_____

(cell) _____(work)_____ (cell)_____(work)_____

DENTAL/ORTHODONTIC INSURANCE : YES ☐ NO ☐

Name of Subscriber:_____ Relationship to patient:_____

Subscriber's date of birth:_____ Social Security Number: _____-____-_____or ID Number:_____

Employer:_____Group Number:_____

Insurance Carrier:_____ Insurance Co. phone number:_____

FOR OFFICE USE: Ortho lifetime max: $_____ Used to date: _____Effective date:_____Age limit:_____

MEDICAL HISTORY

General Health: Good ☐ Fair ☐ Poor ☐ Height_____Weight_____

Presently under medical care for_____

Birth Defects_____

Drugs or medication being taken now (*drug and dose*)_____

Allergic to (medication, metal, etc.) _____

Please check yes or no to the following and date:

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Adopted child	☐	☐	_____	Ear/Nose infections	☐	☐	_____	Heart disorder/ murmur	☐	☐	_____	Lung disorder	☐	☐	_____
Adenoids (removed)	☐	☐	_____	Emotional	☐	☐	_____	Hepatitis	☐	☐	_____	Rheumatic Fever	☐	☐	_____
Allergies	☐	☐	_____	Endocrine disorder	☐	☐	_____	Hospitalized	☐	☐	_____	Scoliosis	☐	☐	_____
Blood/Bleeding problems	☐	☐	_____	Epilepsy	☐	☐	_____	Hyperactivity	☐	☐	_____	Sexually transmitted disease	☐	☐	_____
Bone disorder	☐	☐	_____	Fainting spells	☐	☐	_____	Learning disorder	☐	☐	_____	Speech difficulty	☐	☐	_____
Diabetes	☐	☐	_____	Glaucoma	☐	☐	_____	Liver disorder	☐	☐	_____	Other	☐	☐	_____

☐ ☐ Do you require antibiotic premedication prior to dental appointments?

If yes, which antibiotics do you usually take?_____

Please give us any additional information or details where necessary_____

_____

PLEASE COMPLETE REVERSE SIDE >>>

FAMILY HISTORY

Names and ages of brothers and sisters_____

Other family members with similar dental conditions or orthodontic treatment (names and ages) _____

If so, have we treated any of these family members? Yes ☐ No ☐

Have you had any other experience with or seen another orthodontist? Yes ☐ No ☐ Name _____

MATURATION

Have you grown very much in the past year? Yes ☐ No ☐ How many inches?_____

Female patients: Monthly Periods? Yes ☐ No ☐ Started at age_____

Male Patients: Voice change? Yes ☐ No ☐ Facial Hair? Yes ☐ No ☐

Other indications of pubertal development_____

DENTAL HISTORY

Date of last dental check-up_____

Injury of trauma to the face or teeth_____

Does the patient play a musical instrument?_____

Thumb sucking?_____ discontinued at the age of_____

Has the patient noticed or been diagnosed as having any of the following problems due to a poor bite?

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Worn or sore teeth	☐	☐	_____	Bone and gum recession	☐	☐	_____	Speech difficulty	☐	☐	_____
Loose teeth	☐	☐	_____	Headaches and/or jaw joint problems	☐	☐	_____	Bruxism and/or clenching	☐	☐	_____

PATIENT'S TREATMENT ATTITUDE

Major reason for seeking treatment_____

How did you become aware of the orthodontic problem?_____

Patient interest in treatment:

- ☐ patient wants treatment
- ☐ unwilling but agrees
- ☐ treatment if necessary
- ☐ uncooperative

Questionnaire completed by_____relationship to patient_____

How and when did you first hear about our office?_____

Whom may we thank for referring you to our office?_____

Comments/Concerns_____

PLEASE COMPLETE REVERSE SIDE >>>