Welcome to the orthodontic office of
Dr. Marie Doulaverakis

Date: ________________

PATIENT INFORMATION

NAME ____ NICKNAME _______________________ SEX : ☐ M ☐ F

ADDRESS ____ CITY/STATE __________________________ ZIP _______________

HOME PHONE _______________________ CELL PHONE ________________________ WORK PHONE _________________________
Please circle the number you'd prefer us to confirm your appointments on.

SSN _______________________________________ BIRTHDATE ________________________________ AGE __________________

OCCUPATION _________________________________ EMPLOYER / SCHOOL________________________________ YEARS EMPLOYED ________

SPOUSE'S NAME ____ AGE ___________________________________

SSN ______________________________ BIRTHDATE ______________________ WORK PHONE ____________________________

OCCUPATION ______________________________ EMPLOYER ___________________________________ YEARS EMPLOYED ______

INTERESTS OR HOBBIES____

EMAIL ADDRESS ____

NAME and ADDRESS OF DENTIST ____

DENTIST PHONE _______________________ DENTIST FAX ____________________ DATE OF LAST VISIT _____________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

DO YOU KNOW ANY PATIENTS IN OUR PRACTICE? WHO? ____

PLEASE CHECK REASONS FOR SEEKING AN ORTHODONTIC CONSULTATION:

☐ SUGGESTED BY DENTIST ☐ CROWDING ☐ SPACING ☐ BAD BITE ☐ OVERBITE ☐ EXCESSIVE WEAR

☐ OTHER ____

DENTAL INSURANCE INFORMATION

INSURED'S NAME ____ INSURED'S SSN ___________________________________

INSURANCE CO ____________________________________GROUP # ___________________ INSURANCE PHONE _______________

INSURANCE CO ADDRESS ____

DO YOU HAVE DUAL COVERAGE? ☐ NO ☐ YES **IF YES:** PLEASE COMPLETE BELOW

INSURED'S NAME ____ INSURED'S SSN ___________________________________

INSURANCE CO ____________________________________GROUP # ___________________ INSURANCE PHONE _______________

INSURANCE CO ADDRESS ____

EMPLOYER ____

HEALTH HISTORY

PHYSICIAN'S NAME ____________________ CITY ____________________ LAST SEEN ____________________

YES NO Are you experiencing any health problems? Explain ____________________
YES NO Do you have any history of major illness? Explain ____________________
YES NO Are you currently taking medications or drugs? Please list ____________________
YES NO Are you allergic to any medications or drugs? Please list ____________________
YES NO Women: Are you pregnant?

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING: (CIRCLE YES OR NO)

YES NO AIDS/HIV
YES NO Anemia
YES NO Arthritis, Rheumatism
YES NO Artificial Heart Valves
YES NO Artificial Joints
YES NO Asthma
YES NO Back Problems
YES NO Bleeding, prolonged
YES NO Blood Disease
YES NO Cancer
YES NO Chemical Dependency
YES NO Chemotherapy
YES NO Circulatory Problems
YES NO Congenital Heart Lesions
YES NO Cortisone Treatments
YES NO Cough, persistent or bloody
YES NO Diabetes
YES NO Emphysema
YES NO Epilepsy
YES NO Fainting or dizziness
YES NO Glaucoma
YES NO Headaches or Migraines
YES NO Head or Neck Pain
YES NO Heart Problems
YES NO Hepatitis Type ___________
YES NO Herpes
YES NO High Blood Pressure
YES NO Jaw Pain
YES NO Kidney Disease
YES NO Liver Disease
YES NO Low Blood Pressure
YES NO Mitral Valve Prolapse
YES NO Nervous Problems
YES NO Pace Maker
YES NO Psychiatric Care
YES NO Radiation Treatment
YES NO Respiratory Disease
YES NO Rheumatic Fever
YES NO Scarlet Fever
YES NO Shortness of Breath
YES NO Skin Rash
YES NO Special Diet
YES NO Stroke
YES NO Swollen Feet or Ankles
YES NO Swollen Neck Glands
YES NO Thyroid Problems
YES NO Tonsillitis
YES NO Tuberculosis
YES NO Tumor/growth on head or neck
YES NO Ulcer
YES NO Weight Loss, unexplained
YES NO Sinus Trouble
YES NO Jaundice

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

☐ OTHER CONDITIONS OR PROBLEMS NOT MENTIONED ABOVE ____________________

NEAREST RELATIVE IN CASE OF EMERGENCY ____________________ PHONE ____________________

DENTAL HISTORY

YES NO Injuries to face, mouth or teeth?
YES NO History of speech problems?
YES NO Abnormal swallowing habit (tongue thrusting)?
YES NO Mouth breathing habit, difficulty breathing?
YES NO Missing permanent teeth?
YES NO Extra permanent teeth?
YES NO Periodontal (Gum) problems?
YES NO Any teeth irritating cheek, lip or tongue?
YES NO Clicking or popping of the jaw?
YES NO Difficulty in opening, closing or chewing?
YES NO Pain or soreness in muscles of face or around the ears?
YES NO Clenching or grinding of the teeth while awake or asleep?
YES NO Would you mind wearing braces if needed?
YES NO Have you had any previous orthodontic treatment?
YES NO Has an orthodontist been consulted previously? Who? ____________________ Date ____________________
YES NO Have any family members had orthodontic treatment? Who? ____________________
YES NO Any other information that may be helpful? ____________________

I understand that where appropriate, credit bureau reports may be obtained. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature ____________________ Date ____________________

OFFICE USE:

DATE	*INITIALS*	*CHANGES*	*UPDATE*
		YES / NO	
		YES / NO	
		YES / NO	
		YES / NO	