TEEM ORTHODONTICS PLLC
SHOW YOUR SMILE

14634 Lee Highway Gainesville VA 20155

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PATIENT INFORMATION

Date……

Patient's Name……Date of Birth……..

SocialSecurity#……Age……Ethnicity……Occupation……Gender……..

Address……

Home Telephone ( )……Cell/Work ( )…….

Referred By……

Name of School Patient Attends……

RESPONSIBLE PARTY

Name……Marital Status……..

Address……

Home Telephone ( )……Cell/Work ( )…….

Social Security #……Birthdate……Relationship to Patient……

Employer……Occupation……

Employer Address……..

Spouse's Name……Employer……Occupation……

Employer Address……

Social Security #……Date of Birth……Relationship to Patient……..

Home Telephone ( )……..Cell/Work ( )……

***E-mail*……**

DENTAL INSURANCE

Subscriber Name…….

DOB……SSN # or ID#……

Insurance Company……..Group #……..…

Insurance Co. Address……

Employer……..Ins. Co. Phone #…….....

Do you have secondary coverage? Y/N If yes:……

Subscriber Name…….

DOB……SSN # or ID#……

Insurance Company……..Group #……..…

Insurance Co. Address……

Employer……..Ins. Co. Phone #…….....

Emergency Contact……Phone…….....

I understand that where appropriate, credit report may be obtained.

Signature (Parent's signature if minor)……

DENTAL/MEDICAL HISTORY.

Chief Concern…….

Name of Dentist…….

Address…….....Phone.....

a. Last appointment……..
b. For what…….
c. Do you have toothache……Y/N
d. Does food pack between your teeth……Y/N
e. Do you have bleeding gums……Y/N
f. Do you grind your teeth…….....Y/N

g. Do you suck your thumb/finger or lips……Y/N

h. Do you have sores or lumps in your mouth……..Y/N

i. Have you ever had any injury or blow to your face or jaws……Y/N

j. Do you pain on the face, neck or shoulders……..Y/N

k. Do you have frequent headaches……Y/N

l. Do you have ringing or pain in your ears……Y/N

m. Do you have difficulty opening your mouth……Y/N

n. Do you have pain on chewing/talking or yawning……..Y/N

o. Do your joints make noises upon opening/closure……..Y/N

p. Have you had any treatment for your jaw joint(TMJ)……Y/N

If yes, when and by whom…….

q. Any other information about your dental treatment……..

1. Has patient been under the care of a physician during the past 2 years

other than for routine examination……Y/N

2. Are you taking any medication ……Y/N

If yes, explain……..

a. Do you have any allergies to medication or foods……Y/N

If yes, explain ……

b. Do you bleed easily for long period of time……..Y/N

c. Have you noticed any lumps under your jaw, neck, armpits, chest/breast

……Y/N

d. Do you have chest pains……Y/N

e. Have you had significant weight loss/gain in the past year……Y/N

f. Do you experience shortness of breath when awakening from sleep……Y/N

g. Do you feel overly warm or have frequent fevers……Y/N

h. Have you been informed that you have cancer……Y/N

i. Do you drink alcohol……..Y/N

If yes, how often

j. Do you smoke……..Y/N

k. If yes, how often

l. Are you Pregnant……Y/N

If yes, How many months

m. Are you practicing birth control……Y/N

If yes, explain

n. Have you ever had or have any of the following

Heart Disease	Y/N	High Blood Pressure	Y/N
Hepatitis	Y/N	Anemia	Y/N
Diabetes	Y/N	Arthritis	Y/N
HIV	Y/N	Asthma	Y/N
Epilepsy/Seizures	Y/N	Emotional problems	Y/N
Cold Sores	Y/N	Bone disease	Y/N

Signature……Date……..

Relationship to patient……