Mark Y. Iritani, DDS, PC

Adult Orthodontics

Welcome!

Patient Information

Date_____/_____/_____ **Sex_____**

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ **Birthdate_____/_____/_____** **Social Security #_____/_____/_____**

Cell Phone_____ **Email Address_____**

Name of Dentist_____ **Name of Physician_____**

Name and ages of children_____

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

Do you anticipate a move or transfer in the near future? **Yes_____** **No_____**

Responsible Party Information

Name_____
Last First Middle Marital Status

Mailing address_____
Street City State Zip

How long at this address_____ **Spouse's Name_____**

Employer_____ **Occupation_____** **No. Years Employed_____**

Work Phone_____ **Email Address_____**

Insurance Information

Insured's Name_____ **Social Security #_____/_____/_____**

Insurance Company_____Group #_____Phone #_____

Do you have dual coverage? **Yes_____** **No_____**

Insured's Name_____ **Social Security#_____/_____/_____**

Insurance Company_____Group #_____Phone #_____

Member American Association of Orthodontists

*** I understand that where appropriate, credit bureau reports may be obtained.**

Medical History

Check an of the following which you now are or have been treated for

__	**Anemia**	__	**Asthma**	__	**Arthritis or joint disease**
__	**Bone Disorders**	__	**Cancer**	__	**Fainting or Dizziness**
__	**Epilepsy**	__	**Heart Disease**	__	**Head or neck pain**
__	**Nervous Disorders**	__	**Kidney Involvement**	__	**Liver Disease (Hepatitis)**
__	**Prolonged Bleeding**	__	**Respiratory Disorders**	__	**Rheumatic Fever**
__	**Tuberculosis**	__	**Thyroid Disorders**	__	**Diabetes**
__	**Prosthetic implants**	__	**Venereal Disease**	__	**Herpes II, HIV etc…**

Do you have any disease/disorder or medical condition we should be aware of? **__Yes** **__No**
If yes, please explain_____

Are you in good health? **__Yes** **__No**

At present, are you under medical care? **__Yes** **__No**
If yes, please explain_____

List all drugs or medications currently being taken. Give reasons_____

List any allergies or drug sensitivity_____

Women: Are you or potentially pregnant? **__Yes** **__No**

Dental History

Date of last visit to the dentist_____ **Do you visit the dentist at least once a year?** **__Yes** **__No**

Are you missing any permanent teeth? **__Yes** **__No**

Are you a mouth breather while awake? **__Yes** **__No** **While asleep?** **__Yes** **__No**

Do you snore? **__Yes** **__No**

Have you ever had:

a. Orthodontic treatment?	**__Yes**	**__No**
b. Oral surgery?	**__Yes**	**__No**
c. Periodontal treatment?	**__Yes**	**__No**
d. Your teeth or bite adjusted?	**__Yes**	**__No**
e. Worn a splint or night guard?	**__Yes**	**__No**

Problems of the jaw. Have you ever experienced:

a. Clicking of the jaw?	**__Yes**	**__No**
b. Pain in the jaw joint, ear or side of face?	**__Yes**	**__No**
c. Difficulty in opening or closing?	**__Yes**	**__No**
d. Difficulty in chewing?	**__Yes**	**__No**

Habits. Do you:

a. Bite your fingernails?	**__Yes**	**__No**
b. Clench or grind your teeth while awake or asleep?	**__Yes**	**__No**
c. Bite your lips or cheeks frequently?	**__Yes**	**__No**
d. Hold objects with your teeth (i.e. pens, pencils etc…)?	**__Yes**	**__No**

Do you have headaches? **__Yes** **__No**
Frequency_____ **Location**_____

Has another orthodontist been consulted previously? **__Yes** **__No**

Orthodontic concerns/reason for consultation_____

Signature_____ **Date**_____/_____/_____

Doctor Signature_____ **Date**_____/_____/_____