Steven S. Sabatino DDS, MS, PLLC

Adult Patient History

Date_____

Name_____ Birthdate_____ Age_____

Last First Middle initial

_____Male _____Female _____Height _____Weight

Name you would like to go by: _____

Patient Address: _____

City:_____ State_____ Zip_____ Phone_____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Email _____

Social Security #_____ Drivers License#_____

Occupation_____ Employer _____

Employer Address_____

Hobbies/Interests _____

Name and ages of other members in your family _____

Name of family members that are in our practice _____

Dentist_____ Dentist Phone: _____

Dentist Address: _____

Who may we thank for referring you? _____

Physician_____ Phone # _____

Physician Address: _____

Are you/the Patient: _____Single _____Married _____Divorced _____Widow

Spouse's Name_____ Social Security # _____

Spouse's Birthday_____ Home Address _____

Phone #_____ Occupation _____

Employer Name_____ Address _____

In case of an emergency please contact:_____ Phone_____

Orthodontic Insurance Information

Primary Insurance Information Relationship to Patient_____

Insured's Name_____ Insured's Date of Birth_____

Insured's Social Security #_____ Employer's Name_____

Employer's Address_____ City_____ State_____ Zip_____

Insurance Company_____ City_____ State_____ Zip_____

Insurance Phone #_____ **Name of Dental Plan**_____

(We will need a copy of your "Dental Plan Insurance Card")

Secondary Insurance Information Relationship to Patient_____

Insured's Name_____ Insured's Date of Birth_____

Insured's Social Security #_____Employer's Name_____

Employer's Address_____ City_____ State_____ Zip_____

Insurance Company_____ City_____ State_____ Zip_____

Insurance Phone #_____ **Name of Dental Plan**_____

Dental/Medical History Information

Please circle yes or no to the following questions: Date of last dental exam _____

Yes No Have you ever sucked your thumb or fingers? Until what age?_____
Yes No Have you ever had any injuries to your teeth, face or jaw?
Please explain_____
Yes No Did you have speech therapy? How long?_____
Yes No Have you ever had any abscessed teeth? _____
Yes No Have you ever been informed of missing or extra teeth?
Yes No Do you clench or grind your teeth at night?
Yes No Do you have any pain, clicking or popping during jaw movement?
Yes No Do you get headaches?
Yes No Are you concerned about how your teeth look?
Yes No Do you want your teeth straightened?
Yes No Do you experience your gums bleeding or any soreness?
Yes No Have you ever had any treatment for your gums?
Yes No Does anyone in your family have similar dental conditions?
Yes No Has anyone in your family ever had orthodontic treatment?
Yes No Have you had previous orthodontic consultation or treatment?

What is your chief concern for evaluation and information desired?_____
Who first noticed a possible orthodontic problem? _____
Have you had any x-rays of your teeth taken recently?_____When?_____
Please circle Yes or No (If yes,please) fill in the details.)
Yes No Are you taking any medications?_____
If yes, Please list any medications: _____
Yes No Are you allergic to any medications?_____
If yes, please list medications:_____
Yes No Are you presently under care of a physician? If yes, for what reason? _____
Have you ever had any major illness or major surgery? _____
If so please explain: _____
Have you ever been hospitalized?_____ If yes, for what reason? _____
Have you had your tonsils or adenoids removed?_____ At what age?_____
Do you have any of the following: Asthma_____ Allergies_____ Hayfever_____
Do you suffer from frequent throat infections? _____
Do you breathe mostly through your: Nose:_____ Mouth_____ Both_____ Uncertain_____

Yes	No	Abnormal Bleeding	Yes	No	Heart Problems	Yes	No	Sinusitis
Yes	No	Anemia	Yes	No	Hepatitis-Type_____	Yes	No	Thyroid Disease
Yes	No	Arthritis	Yes	No	Herpes	Yes	No	Tuberculosis
Yes	No	Blood Disorders	Yes	No	High Blood Pressure	Yes	No	Aids
Yes	No	Bone or joint disorders	Yes	No	Hyperactive	Yes	No	HIV+
Yes	No	Cancer or Tumor	Yes	No	Kidney Involvement	Yes	No	Contact Lenses
Yes	No	Diabetes	Yes	No	Liver Disease			
Yes	No	Dizziness/Fainting	Yes	No	Lung/Respiratory Disease	Yes	No	Other_____
Yes	No	Emotional Problems	Yes	No	Nervous Disorders			_____
Yes	No	Endocrine Problems	Yes	No	Pneumonia			
Yes	No	Epilepsy	Yes	No	Prolonged Bleeding			
Yes	No	Glaucoma	Yes	No	Rheumatic Fever			
Yes	No	Heart Murmur	Yes	No	Rheumatic Heart Disease			

FOR WOMEN ONLY: Are you pregnant? _____
Remarks: _____

Benefits of Orthodontics; Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part, and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime,and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understood the above paragraph, and that I have truthfully to the best of my ability answered all the above questions.

Patient/Parent Signature_____ Date_____
The above information is true to the best of my knowledge. I hereby authorize you to release and/or share this information with my general dentist and/or physician. I understand that, where appropriate, credit bureau reports may be obtained.

Date_____ Signature _____