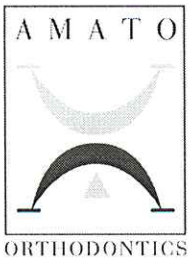

STEVEN M. AMATO, D.D.S., M.S.

Orthodontics for Adults and Children

PLEASE COMPLETE THE FOLLOWING **PATIENT** INFORMATION BEFORE EXAM

Name _____
Last First Middle Birth Date

Address _____
Number Street City, State Zip Code Telephone

PARENT INFORMATION

Mother's Name _____
Last First Middle Social Security # Birth Date

Employer _____
Name Address Telephone

Father's Name _____
Last First Middle Social Security # Birth Date

Employer _____
Name Address Telephone

Parent's Address _____
Number Street City, State Zip Code Telephone

If parents are separated, non-custodial parent _____
Name

_____
Address Telephone

PERSONAL INFORMATION

By whom were you referred? _____ When? _____

Dental Insurance? ___ Yes ___ No Insurance Co. Name? _____

Hobbies or Interests? _____

Do you play a musical instrument? _____

PATIENT HISTORY

MEDICAL HISTORY

Family Physician _____ Specialty _____

Address _____ Area Code (____) Telephone _____

Additional Physician _____ Specialty _____

Address _____ Area Code (____) Telephone _____

Height _____ Weight _____ Age _____ Date of last complete medical examination _____

Please circle YES or NO. If YES, please fill in details.

Yes No Do you have a current medical problem? What? _____

Yes No Do you have heart trouble? What kind? _____

Yes No Have you had rheumatic fever? When? _____

Yes No Do you have high or low blood pressure? Is it controlled? _____

Yes No Have you had pains in the chest or shortness of breath? _____

Yes No Has your physician ever told you that you are anemic? _____

Yes No Have you ever had a stroke? When? _____

Yes No Have you ever had diabetes? How is it controlled? _____

Yes No Are you subject to fainting or dizziness? When? _____

Yes No Do you have frequent headaches? How often? _____

Yes No Do you have problems with insomnia? How often? _____

Yes No Do you have any nervous disorders? How is it controlled? _____

Yes No Do you take tranquilizers or sedatives? How often? _____

Yes No Do you take aspirin? How often: _____

Yes No Are you allergic to any medications? What? _____

Yes No Have you been advised not to take any medication? What? _____

Yes No Do you have asthma or hay fever? How is it controlled? _____

Yes No Have you ever had tuberculosis? When? _____

Yes No Have you ever been diagnosed as having AIDS or HIV? _____

Yes No Have you ever had infectious hepatitis? When? _____

Yes No Do you have arthritis? How is it controlled? _____

Yes No Have you ever had a tumor or cancer? How was it treated? _____

Yes No Have you had any major operations? What kind? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Are you taking any medications? Please list:

Taking _____ for _____ Taking _____ for _____

Taking _____ for _____ Taking _____ for _____

Taking _____ for _____ Taking _____ for _____

FOR WOMEN

Yes No Are you pregnant? Expected delivery date _____

Yes No Are you on birth control medication? _____

PATIENT HISTORY

DENTAL HISTORY

Family Dentist _____ Period of Treatment _____

Address _____ Area Code (____) Telephone_____

Other Dentist _____Specialty _____ Period of Treatment _____

Address _____ Area Code (____) Telephone_____

Date of last complete dental examination _____

What is you immediate concern? _____

Have you ever seen an orthodontist? _____ If so, when? _____

Please circle YES or NO. If YES, please fill in details.

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

What _____

Yes No Have you lost any teeth? From what cause? _____

Yes No Have you ever had orthodontic treatment? When? _____

Yes No Do you have any growths or swellings in your mouth? How long have they existed? _____

Yes No Do you have any difficulty in swallowing? _____

Yes No Do your gums bleed when brushing your mouth? _____

Yes No Do you avoid brushing any part of your mouth? Why? _____

Yes No Have you ever been told you have periodontal or gum disease? _____

Yes No Is any part of your mouth sensitive to temperature, pressure or food or drink? What? _____

Yes No Have you ever had a bad reaction to a dental anesthetic? When? _____

Yes No Does food catch between your teeth? _____

Yes No Do you have any pain or soreness around your eyes or ears or other parts of your face?

When? _____

Yes No Are you aware of stiff neck muscles? How often? _____

Yes No Do you ever awaken with an awareness of your teeth or jaw? How often? _____

Yes No Are you aware of clenching your teeth during your daytime hours? How often? _____

Yes No Have you ever been told you grind your teeth during sleep? How often? _____

Yes No Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

Yes No Do you have difficulty in opening your mouth widely? _____

Yes No Do you have "tension" headaches? How often? _____

Yes No Do you have an unpleasant taste or odor in your mouth? _____

Yes No Are you satisfied with your teeth and appearance? _____

Yes No Are you willing to wear braces if they are necessary to restore your good dental health? _____

Yes No Do you have allergies to: Seasonal grasses ____ Drugs ____ Food ____ Other _____

Yes No Do you snore when sleeping? _____

Yes No Do you breathe through your mouth? Sometimes _____ Usually _____

–Please use the back of this page for additional information–

I hereby state that I have truthfully to the best of my ability answered all the above questions. I understand that where appropriate, Credit bureau reports my be obtained.

Signature_____ Date_____

PLEASE USE THIS SPACE FOR ANY NECESSARY EXPLANATIONS WHICH MAY ASSIST US IN THE PROPER DIAGNOSIS OF ANY PROBLEMS YOU MAY HAVE.

OFFICE USE ONLY

DATE	HX UPDATE