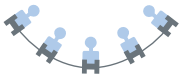

Ferry Orthodontics

599 PONTIAC AVENUE CRANSTON, RI 02910 401.781.2900
25 SOUTH COUNTY COMMONS WAY WAKEFIELD, RI 02879 401.284.3033

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City Zip

Cell Phone _____ Home Phone _____ Work Phone _____

Birthdate _____ E-mail Address _____

Full Name of Parent or Legal Guardian _____

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

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home Phone _____ Work Phone _____

Relationship to Patient _____

Social Security # _____ Birthdate _____

Employer _____

Employer's Address _____
Street City Zip

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's ID #_____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security #_____

Insurance Company _____ Group No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Residence_____
Street City Zip

Phone _____

Signature (Parent's signature if minor) _____

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DENTAL HISTORY

Dentist _____ Date of Last Visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

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

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth or teeth? _____

Yes No Is any part of your mouth sensitive to temperature or pressure? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No What is your attitude toward receiving orthodontic treatment? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the night? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____

Yes No Are you aware that some appointments will be during school/work hours? _____

Please list some hobbies or interests _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____

Phone _____

Please circle Yes or No (If yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

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Yes No Have you had any major operations? _____

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

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	GI Disorders	HIV/AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?_____

_____

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in 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 teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Ferry to perform a complete orthodontic evaluation.

Signature _____ Date _____