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: _____

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? _____

Address _____

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 _____

Temporomandibular Joint Questionnaire

Name_____ **Birthdate**_____ **Age**_____ **Date**_____

Directions: If you can answer YES to the question asked, put a circle around the YES.
If you can answer NO to the question asked, put a circle around the NO.

Please answer all the Questions.

1. Do you have clicking, popping or grating noise in your right jaw joint? Yes No
   In your left jaw joint? Yes No
2. When did you first notice the noise? _____
3. Has the noise recently become more pronounced? Yes No
4. Do you have pain in or around the right joint? Yes No
5. Do you have pain in or around the left joint? Yes No
6. When did you first notice the pain? _____
7. Has the pain recently become more pronounced? Yes No
   When? _____
8. Is the pain worse: Mornings_____ At Meals_____ Evenings_____ No Specific Time_____
9. Is the pain: Dull _____ Continuous _____ Stabbing _____ Intermittent _____
   Throbbing _____ Other _____
10. Does the pain sometimes feel like it is in your ear? Yes No
11. Do you think this problem has affected your hearing? Yes No
12. Does your jaw problem interfere with your normal activities? Yes No
13. Are you taking or have you taken medication for this problem? Yes No
14. Did anything occur which might be related to the onset of this problem? Yes No
    Please explain: _____
15. Do you have any difficulty chewing? Yes No
    Because of: Pain in Joint _____ Limited Opening_____
    Pain in Teeth_____ Missing Teeth _____
    Clicking_____ Other_____
16. Has your mouth ever locked open so you were unable to close it? Yes No
    Explain: _____
17. Have you had problems opening your mouth wide? Yes No
    Explain: _____
18. Please indicate the time sequence in which you became aware of the following:
    (1st, 2nd, 3rd, etc.) Number only those problems which apply to you:
    Pain_____ Noise_____ Limited Opening_____ Locking_____
19. Which aspects of your problems concern you the most? _____
    _____
20. Are you aware of clenching your teeth? Yes No
21. Do you grind your teeth? Yes No
22. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in immediate family or other stressful events? Yes No
23. Do you think nervous tension seems to affect this problem? Yes No
24. Have you had problems with other joints? Yes No
25. Have you had orthodontic treatment prior to this appointment? Yes No
26. Have you had recent dental treatment? Yes No
27. Have you had x-rays taken for this problem? Yes No
    When_____ Where _____
28. Have you had previous treatment for this problem? Yes No