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 ________________________