Drs. Najem & Lehky Orthodontics, LLC

Wade J. Najem II, D.D.S., M.S.D. **Lisa A. Lehky, D.D.S.**

CONFIDENTIAL PATIENT INFORMATION
(ADULT)

Date _____

Last Name _____ First _____ Middle _____

Nickname _____ DOB_____/_____/_____ Age _____ Sex _____

Address _____ City _____ State ____ ZIP _____

Home Phone _____ Cell _____ Email _____

Occupation/Employer _____ Dental Insurance Coverage _____ Yes _____ No

Work Phone _____ SSN ____-___-_____ DOB _____/____/_____

Insurance Co. _____ Policy/ID # _____ Group # _____

Spouse Last Name _____ First _____ MI _____

Occupation/Employer _____ Dental Insurance Coverage _____ Yes _____ No

Work Phone _____ SSN ____-___-_____ DOB_____/____/_____

Insurance Co. _____ Policy/ID # _____ Group # _____

Emergency Contact _____ Relationship _____ Phone _____

Dentist _____ Dentist Phone _____

Dentist Address _____ City _____ State ____ ZIP _____

Physician _____ Physician Phone _____

Physician Address _____ City _____ State ____ ZIP _____

Other family members treated in our office _____

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

DENTAL HISTORY

Yes ___ No ___ Supernumerary (extra) or congenitally missing teeth?
Yes ___ No ___ Chipped or otherwise injured primary (baby) or permanent teeth?
Yes ___ No ___ Teeth sensitive to hot or cold; teeth throb or ache?
Yes ___ No ___ Jaw fractures, cysts, mouth infections? Yes ___ No ___ "Dead Teeth," root canals treated?
Yes ___ No ___ Bleeding gums, bad taste, mouth odor? Yes ___ No ___ Periodontal "Gum" problems?
Yes ___ No ___ Food impaction between teeth? Yes ___ No ___Taking any forms of fluoride?
Yes ___ No ___ History of speech problems? Yes ___ No ___ Mouth breathing, snoring, difficulty breathing?
Yes ___ No ___ Pain in jaw or ringing in ears? Yes ___ No ___ Difficulty in chewing or jaw opening?
Yes ___ No ___ Thumb, finger sucking habit? If Yes, until what age? ___
Yes ___ No ___ Abnormal swallowing (tongue thrusting) habit?
Yes ___ No ___ Tooth grinding, jaw clenching, clicking, locking?
Yes ___ No ___ Pain or soreness in the muscles of the face or around the ears?
Yes ___ No ___ Aware of loose, broken, or missing fillings?
Yes ___ No ___Any teeth irritating cheek, lip, tongue, or palate?
Yes ___ No ___ Concerned about spaced, crooked, protruding teeth?

CONTINUED ON BACK

DENTAL HISTORY CONTINUED

Yes ___ No ___ Aware or concerned about under or over developed jaw?
Yes ___ No ___ Any relative with similar tooth or jaw relationships?
Yes ___ No ___ Any wisdom teeth problems? If removed, when? _____
Yes ___ No ___ Have you had any serious trouble associated with any previous dental treatment?
Yes ___ No ___ Onset of puberty? If Yes, approximate age _____
Yes ___ No ___ Have you had a prior orthodontic examination or treatment?
Yes ___ No ___ Have you been under a dentist's care? Specialist _____ Other _____
Date of most recent dental examination _____
Yes ___ No ___ Have you had any periodontal (gum) treatment?
How often do you brush _____ Floss _____
What is the primary reason for your visit? _____

MEDICAL HISTORY

Yes ___ No ___ Allergies or drug reactions? If Yes, please list _____
Yes ___ No ___ Premedicate for dental procedures? _____
Yes ___ No ___ Birth defects or hereditary problems? Yes ___ No ___ Bone fractures, major accidents?
Yes ___ No ___ Rheumatoid or arthritic conditions? Yes ___ No ___ Endocrine or thyroid problems?
Yes ___ No ___ Kidney problems? Yes ___ No ___ Diabetes?
Yes ___ No ___ Cancer or treatment for a tumor? Yes ___ No ___ Polio, mono, tuberculosis, pneumonia?
Yes ___ No ___ AIDS or HIV positive? Yes ___ No ___ Hepatitis, jaundice or liver problems?
Yes ___ No ___ Hay fever, asthma, sinus trouble, hives? Yes ___ No ___ Eye, ear, nose, throat conditions?
Yes ___ No ___ High or low blood pressure? Yes ___ No ___Frequent headaches, colds, sore throats?
Yes ___ No ___ Fainting spells, seizures, epilepsy or neurological problems?
Yes ___ No ___ Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, rheumatic heart)?
Yes ___ No ___ Are you currently taking medication, nutrient supplements, nonprescription medications?
If Yes, please list _____
Yes ___ No ___ Operations, hospitalizations? If Yes, please list _____
_____
Yes ___ No ___Other physical problems or symptoms? If Yes, please list _____
_____
Yes ___ No ___ Are you being treated by another health care professional? If Yes, please list Dr(s) and reason
_____
Date of most recent physical exam _____

CONSENT

To make a complete orthodontic diagnosis, it is necessary to obtain diagnostic records consisting of radiographs, photographs, and study models. Do we have permission to obtain these records if you decide to proceed with treatment?

Yes ___ No ___ "I do understand that I am fully responsible to pay for the diagnostic records fee should I choose not to proceed with treatment. If I do proceed with treatment, the diagnostic records fee is included in the total case fee."

"I have read and understand the above questions. I will not hold my orthodontist or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history or medical/dental status after beginning orthodontic treatment, I will inform this practice."

Signature _____ Date _____