GERLEIN
ORTHODONTICS

Date: _____

Patient Information

Patient's Name: _____
Last *First* *Middle* *Preferred Name*

Sex: Female Male Marital Status: Single Married Widowed Divorced

Address: _____
Street *City* *State* *Zip*

Home Telephone: _____ Work Telephone: _____

Birthdate: _____ Age: _____ Social Security #: _____

Dentist: _____ Telephone: _____ Referred By: _____

Patient's Physician: _____ Telephone: _____

Email address: _____

Responsible Party Information

Name: _____
Last *First* *M.I.*

Marital Status: Single Married Widowed Divorced _____
Relationship to Patient

Address: _____
Street *City* *State* *Zip*

Home Telephone: _____ Work Telephone: _____

Birth date: _____ Age: _____ Social Security #: _____

Employer: _____ Occupation: _____

Name: _____ _____
Last *First* *M.I.* *Relationship to Patient*

Address: _____
Street *City* *State* *Zip*

Home Telephone: _____ Work Telephone: _____

Birth date: _____ Age: _____ Social Security #: _____

Employer: _____ Occupation: _____

Emergency Information

Contact Name: Telephone:

5550 Friendship Boulevard Suite 320 Chevy Chase Maryland 20815 T: 301-951-4114 F: 301-951-6166

MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor
Under Treatment: Yes No Specify:_____
Date of Last Dental Cleaning: _____

PRESENT DRUGS OR MEDICATION

Has patient been under care of a physician during the past two years other than for routine examinations? Yes No
Birth Defects Yes No Specify: _____
Current Medications:_____

The following conditions are of interest to the orthodontist. Has the Patient ever had:

Asthma	Yes	No	Diabetes	Yes	No	Heart Disease	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Hearing Disorder	Yes	No
Blood Disease	Yes	No	Endocrine Problems	Yes	No	Head or Face Injury	Yes	No
Bone Disorders	Yes	No	Emotional Problems	Yes	No	Rheumatic Fever	Yes	No
AIDS	Yes	No	HIV Infections	Yes	No			

Comments: _____

Does the Patient:
1. Have allergies to: Seasonal grasses: _____ Food: _____
Drugs: _____ Other: _____
2. Snore When Sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually Comments _____
4. Have frequent colds? Yes No
5 Have frequent sore throat or tonsillitis? Yes No

Has patient received medical treatment from allergist or ear, nose, and throat specialist? Yes No
If yes: When: _____ By whom: _____
Tonsils removed: Yes No Adenoids Removed: Yes No
Have any teeth been injured due to accidents or blows to the mouth? Yes No
Has the patient received or been requested to receive speech correction? Yes No

Thumb sucking: Yes No / Until age: _____ Grinding teeth: Yes No
Finger sucking: Yes No / Until age: _____ Tongue thrusting: Yes No
Lip-biting or sucking? Yes No Other Habits: _____

Has the patient had any unusual dental experiences?
Specify: _____
Has the patient had previous orthodontic consultation or treatment? Yes No
Date: _____ Dr.: _____
Are there any other medical, dental or surgical problems not covered above? Yes No
Specify: _____
Patient:
Do you have pain in the face, neck or shoulders? Yes No
Do you have frequent headaches? Yes No
Do you have recurring tooth pain or sensitivity? Yes No
Do you have ringing, fullness or pain in your ears? Yes No
Do you have difficulty opening your mouth or does your jaw get “stuck” or “locked”? Yes No
Do your joints make noises upon opening or closure? Yes No
Do you have difficulty or pain with chewing, talking or yawning? Yes No
Do you grind or clench your teeth? Yes No
Do you have arthritis? Yes No
Have you had any previous treatment for your jaw joint (TMJ problem)? If so,
_____
When and by whom? _____

Signature: _____ **Date:** _____

-FOR COMPLETION BY THE DOCTOR
_____
_____
_____