Howard M. Freedman DDS, PC

Patient's Information

Date _____

Patient's Name _____ / _____ / _____ Sex _____
Last First Middle Initial

Address _____ / _____ / _____ / _____
Street City State Zip

Home Phone ( ) _____ Alternate or Cell phone ( ) _____

Birthdate _____ Age _____ School _____ Grade _____

Other family members seen in our office?: _____

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

Responsible Party Information

Name _____ / _____ / _____ Marital status _____
Last First Middle Initial

Address _____ / _____ / _____ / _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Previous address (if less than 3 yrs.) _____ / _____ / _____ / _____
Street City State Zip

SSN _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Years employed _____

Spouse's Name _____ / _____ SSN _____ Birthdate _____
Last First

Employer _____ Occupation _____ Yrs employed _____ Work Ph _____

Orthodontic Insurance Information

Insured's Name _____ ID # _____

Insurance Company _____ Birthdate _____ Relationship _____

Insurance Address _____ Phone _____

Do you have dual coverage? Yes ☐ No ☐ if yes:

Insured's Name _____ ID # _____

Insurance Company _____ Birthdate _____ Relationship _____

Insurance Address _____ Phone _____

Emergency Information

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Phone _____

If patient has dental insurance benefits, authorization is granted for release of treatment information to the insurance carrier and for direct insurance payment(s), not to exceed customary charges for services rendered, to Dr. Howard M. Freedman. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if a minor) _____

Updates (date and initial) _____ _____ _____ _____ _____

• CONFIDENTIAL (for record and pretreatment evaluation)

Medical History

Patient's Physician _____ City _____

Is patient in good health? _____

What medications is patient taking now? _____

List any allergies _____

Is there a history of or problem with:	No	Yes		No	Yes
Diabetes / Excessive thirst	___	___	Hepatitis	___	___
Heart / Lung disease	___	___	Bronchial disorder / Pneumonia	___	___
Kidney / Liver disease / Jaundice	___	___	Herpes	___	___
High blood pressure / Low blood pressure	___	___	Sinus problems / Frequent cough	___	___
Blood diseases / Hemophiliac / Anemia	___	___	Blood transfusion	___	___
Epilepsy / Seizures	___	___	AIDS / AIDS Related Complex	___	___
Fainting or dizziness / Nervous disorder	___	___	Have you had prolonged bleeding when cut?	___	___
Tuberculosis	___	___	Do you wear contacts?	___	___
Rheumatic fever	___	___	Women - are you pregnant?	___	___

Other - Please describe: _____

Dental History

Patient's Dentist _____ City _____

How often does patient see their dentist? _____

Has patient had an unfavorable reaction to previous dental care? _____

Has patient had previous orthodontic care? If so, please name orthodontist, location, date and treatment. _____

_____

Reason for orthodontic examination? _____

Would patient object to wearing orthodontic appliances (braces) should they be indicated? _____

Is there a history of or problem with:	No	Yes		No	Yes
Teeth throb or ache / Sensitivity to hot or cold	___	___	Wisdom tooth problem or removal	___	___
Irritations to cheek, lip, tongue, palate	___	___	Presently have missing teeth	___	___
Frequent canker sores / Cysts / Abscess	___	___	Loose, broken or missing fillings	___	___
Lip, Cheek or Tongue biting	___	___	Crown or bridge work	___	___
Food impaction between teeth	___	___	Chipped or Injured teeth	___	___
Bleeding gums / Gingivitis	___	___	Eye, ear, nose, sinus or throat condition	___	___
Gum recession / Pockets / Mouth odor	___	___	Difficulty breathing or chewing	___	___
Bone loss / Loose teeth	___	___	Tongue-thrusting, mouth-breathing habit	___	___
Permanent or extra teeth removed or impacted	___	___	Thumb or finger sucking habit Until Age: _____	___	___

TMJ – Facial Pain History

Please answer the following:	No	Yes		No	Yes
Do you awaken with awareness of your teeth or jaws?	___	___	Do you have difficulty in opening your mouth widely?	___	___
Are you aware of clenching your teeth during the day?	___	___	Do your front teeth get sore for no apparent reason?	___	___
Do you grind your teeth during sleep?	___	___	Does your jaw lock or feel like it might?	___	___
Do you have pain or tenderness around your eyes, ears or other parts of your face?	___	___	Do you ever hear clicking, popping or grating sounds from your jaw joints?	___	___
Do you have frequent headaches or neckaches?	___	___	Are you in pain from your jaw joint or muscles?	___	___
Do your jaw muscles become tired easily from chewing?	___	___	Have you ever received a severe blow to the side of the head or jaw?	___	___
Do you have a problem with insomnia?	___	___			
Do you take aspirin frequently?	___	___	Have you ever had problems with your ears, such as ringing or change of hearing?	___	___
Are you taking any tranquilizers, muscle relaxants or anti-depressants?	___	___	Do you notice excessive wear on any of your teeth?	___	___
Have you ever had arthritis?	___	___	Has your level of emotional stress changed recently?	___	___
Have you ever been treated for problems of your jaw joint or for facial muscle spasms?	___	___	When did symptoms first start? _____		