

I.R. TAKEN _____

**ROBERT J. GOLDMAN, D.D.S.,
ELLIOT S. TAYNOR, D.D.S., P.C.
PATRICK J. SABO, D.M.D.
MARK A. RIENECKER, D.D.S.**

N.P. APPT. _____

CONFERENCE _____

PRACTICE LIMITED TO ORTHODONTICS FOR ADULTS AND CHILDREN

Patient's Name (print) _____
(FIRST) (MIDDLE INITIAL) (LAST)

Address _____ Zip Code _____ Email Address _____

Male Female Telephone: Home _____ Business _____ Cell _____

Referred By _____

Birth Date _____ Birthplace _____ Married () Single () Divorced () Separated () Widowed ()
(MONTH) (DATE) (YEAR) (CITY) (STATE)

Dentist's Name _____ of _____ Date of Last Dental Checkup _____
(CITY)

Physician's Name _____ Date of Last Medical Checkup _____

Your Occupation _____ Your Social Security Number _____

Employer & Address _____

Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer & Address _____ Spouse's Birth Date _____

Spouse's Social Security Number _____ Spouse's Telephone (Bus) _____ (Cell) _____

Children's Names and Ages _____

Are any family members currently in treatment? _____ If so, who? _____
Currently wearing braces? _____
Wearing Retainers? _____ Has an appliance _____ Invisalign _____
Waiting to begin treatment? _____

1. WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

2. Are you in good health? _____ 3. Do you have regular medical examinations? _____

4. Has you ever had any of the following (please check)
Anemia _____ Hepatitis _____ Liver or kidney disease _____ **Allergies to any drugs** _____
Diabetes _____ Hives _____ Jaw pain _____ Mitral valve prolapse _____
Asthma _____ Jaundice _____ Rheumatic fever _____ Handicaps or disabilities _____
Epilepsy _____ Pneumonia _____ Blood disorders _____ HIV / AIDS _____
Hay fever _____ Heart disease _____ Chronic headaches _____ Cancer _____
Hemophilia _____ Migraines _____ Fainting _____

5. Do you require pre-medication for any condition? _____

6. Is there anything else we should know about your general health? _____

7. Do you have any allergies to medications, food, latex, etc? _____

8. Please indicate any medications you are currently taking. _____

9. Have there been any injuries to the face, mouth, teeth, or chin? If yes, please explain _____

10. Are you a mouth-breather? If yes, please explain _____

11. Is there a hereditary background that might contribute to your dental problem

12. Have you ever had any pain / tenderness in your jaw joint (TMJ)? _____

13. Other Remarks _____

(Your signature) (Today's date)