Milberg Orthodontics

Diane J. Milberg, D.D.S., M.S.D.
Laura Milberg Rein, D.M.D., M.S.

About You

Name: _____

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other:_____

I prefer to be called: _____

Email:_____

Sex: ☐ Male ☐ Female SS#:_____

DOB: _____

Home Address: _____

_____

City State Zip

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home#: _____

Cell#: _____

Wk#: _____Ext: ____

Employer: _____

Occupation: _____

Who may we thank for referring you?: _____

Other family members seen by us: _____

Previous/Present General Dentist: _____

Dentist #: _____ Last Visit Date: _____

Spouse/Closest Relative

His/Her Name: _____

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other:_____

Relationship to patient:_____

Address(If different than patient):_____

_____

Home#(If different)_____

Cell#:_____

Work#_____Ext:_____

Occupation:_____

Responsible Party

Person Responsible for Account: _____

(If information is same as above please leave blank)

Billing Address: _____

_____

City State Zip

Home#:_____

Cell#_____

SS#: _____ DOB:_____

Relationship to Patient:_____

Primary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #:_____

Group #:_____

Subscriber Name:

_____

First Middle Last

Relationship to Patient: _____

Subscriber DOB _____

SS#: _____

Employer: _____

Orthodontic Coverage?: ☐ Yes ☐ No ☐ Don't Know

Secondary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____

Insurance Co. Phone #: (_____)_____

Group #:_____

Subscriber's Name:

_____

First Middle Last

Relationship to Patient: _____

Policy Owner's DOB: _____

SS#: _____

Employer: _____

Orthodontic Coverage?: ☐ Yes ☐ No ☐Don't Know

Medical History

Physician's Name: _____

Physician's #: _____

City, State:_____

Last Visit Date: _____

Are you currently under the care of a physician?

☐Yes ☐No, if so explain: _____

Your current health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐Yes ☐No

Are you taking any prescription, over-the-counter, or herbal supplement drugs? ☐Yes ☐No

If so please list each one: _____

_____

Do you need to be pre-medicated for dental work?

☐Yes ☐No

For Women:

Are you pregnant? ☐Yes ☐No

Are you anticipating becoming pregnant? ☐Yes ☐No

Now or in the past, have you had:

☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No AIDS or HIV +
☐ Yes ☐ No Alcohol/Drug Abuse
☐ Yes ☐ No Anemia
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial Bone/ Joint/ Valves
☐ Yes ☐ No Asthma/Hay Fever/Sinus Trouble
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer/Chemotherapy
☐ Yes ☐ No Colitis
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Difficulty Breathing
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting Spells
☐ Yes ☐ No Frequent Headaches
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Heart Attack/ Surgery
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Herpes/Fever Blisters
☐ Yes ☐ No High/Low Blood Pressure
☐ Yes ☐ No Hospitalized for Any Reason
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Psychiatric Problems
☐ Yes ☐ No Rheumatic/Scarlet Fever
☐ Yes ☐ No Seizures
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problem
☐ Yes ☐ No Tonsil or Adenoid Conditions
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Ulcers
☐ Yes ☐ No Venereal Disease

Allergies or reactions to any of the following:

☐ Yes ☐ No Local Anesthetics
☐ Yes ☐ No Aspirin
☐ Yes ☐ No Ibuprofen (Motrin, Advil)
☐ Yes ☐ No Penicillin or other antibiotics
☐ Yes ☐ No Sulfa Drugs
☐ Yes ☐ No Codeine or other narcotics
☐ Yes ☐ No Metals (jewelry, clothing snaps)
☐ Yes ☐ No Latex
☐ Yes ☐ No Acrylics
☐ Yes ☐ No Animals
☐ Yes ☐ No Foods
☐ Yes ☐ No Other substances_____

Now or in the past have you had:

☐ Yes ☐ No Permanent or "extra" teeth removed
☐ Yes ☐ No Supernumerary/congenitally missing teeth
☐ Yes ☐ No Chipped/Injured teeth
☐ Yes ☐ No Sensitive Teeth
☐ Yes ☐ No Jaw fractures
☐ Yes ☐ No "Dead" teeth or root canals treated
☐ Yes ☐ No Periodontal/Gum treatment
☐ Yes ☐ No Frequent Cold/Canker Sores
☐ Yes ☐ No Thumb, finger, or sucking habit
☐ Yes ☐ No Tongue Thrust Habit
☐ Yes ☐ No Mouth breathing. Snoring
☐ Yes ☐ No Tooth grinding or jaw clenching
☐ Yes ☐ No Any pain/clicking/locking in jaw
☐ Yes ☐ No Any pain soreness in muscles around face/ear
☐ Yes ☐ No Difficulty in chewing or jaw opening
☐ Yes ☐ No Have you been treated for TMJ
☐ Yes ☐ No Aware of loose/broken/missing fillings
☐ Yes ☐ No Any teeth irritating cheek, lip, tongue
☐ Yes ☐ No Any wisdom teeth problems
☐ Yes ☐ No Serious trouble associated with previous dental treatment
☐ Yes ☐ No Ever had a prior orthodontic examination or treatment

Brush Daily? ☐ Yes☐ No Floss Daily? ☐Yes ☐No

What concerns you about your teeth?_____

_____

_____

I have read and understand the above questions. I will not hold Dr. Diane J. Milberg or her team responsible for any errors or omissions that I have made in the competition of this form. If there are any changes later to this history record or medical/ dental status, I will inform this practice. I authorize the dental staff to perform the necessary dental services that I may need.

Signature:_____Date:_____