WELCOME TO

DR. CHARLES P. CANEPA

orthodontist

About You

Today's date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Birthdate: _____

Age: _____

SS#: _____

Home address: _____
APT/CONDO#

_____
CITY STATE ZIP

Home#: _____

Cell#: _____

Work#/Ext.: _____

Employer: _____

Employer's address: _____

_____

How long there? _____

Occupation: _____

Where & when are best times to reach you? _____

Whom may we THANK for referring you? _____

Other family members seen by us? _____

General dentist: _____

Last visit date: _____

Dental History

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your chin? ☐ Yes ☐ No

Do you have any speech problems? ☐ Yes ☐ No

Do you generally breathe through your mouth? Awake? ☐ Yes ☐ No

Asleep? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's name: _____

Phone#: _____

Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

_____

For women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Week# _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N	Anemia Radiation Treatment	Y N	Heart Surgery/Pacemaker
Y N	Artificial Bones/Joints	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma / Arthritis	Y N	High/Low Blood Pressure
Y N	Blood Transfusions	Y N	HIV+/AIDS
Y N	Cancer/Chemotherapy	Y N	Hospitalized For Any Reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes/Tuberculosis (TB)	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug/Alcohold Abuse	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema/Glaucoma	Y N	Severe/Frequent Headaches
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Shingles
Y N	Fever Blisters/Herpes	Y N	Sinus Problems
Y N	Heart Attack/Stroke	Y N	Ulcers/Colitis
Y N	Heart Murmur	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metal Plastic	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs that you are allergic to: _____

_____

Spouse Information

His/Her Name: _____

Employer: _____

Work#/Ext. _____

SS#: _____

Birthdate: _____

Person Responsible for Account

Name: _____

Work#/Ext.: _____

Home#: _____

Billing Address: _____

_____

CITY STATE ZIP

Relation: _____

SS# _____

Employer: _____

Additional Comments

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Orthodontic Dental Insurance Information

Insurance Company Name: _____

Insurance Company Address: _____

_____

Insurance Company Phone#: _____

Group #: _____

Name of Subscriber: _____

Subscriber's Birthdate: _____

Subscriber's Employment Status: _____

Social Security# / Insurance ID#: _____

Employer's Name: _____

Employer's Address: _____

_____

Employer's Phone#: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Work#: _____ Home#: _____

Thank you for filling out this form completely!

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my understanding that I must notify this office with any changes in my medical status.

_____

SIGNATURE DATE

Our Office is Committed to Meeting and Exceeding the Standards of Infection Control Mandated by OSHA, the CDC, and the ADA.