NEW WAVE
PEDIATRIC DENTISTRY
AND ORTHODONTICS

482 Merrick Rd
Lynbrook, NY 11563
T 516.837.WAVE (9283)
F 516.837.9288

DENTAL HISTORY - ADULT

Date: _____

Patient's Name: _____ Age: _____ Birthdate: _____

I prefer to be called (nickname): _____ Social Security #: _____ Sex: ☐M ☐F

Email Address: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

Employed by: _____ Occupation: _____ Work Phone: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed Home Phone: _____

Spouse's Name: _____ Occupation: _____

Address: _____ Cell Phone: _____ Social Security #: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

DENTAL INSURANCE

PRIMARY INSURANCE CO: _____ **ID.#:** _____ **EMPLOYED BY:** _____

INSURED'S NAME: _____ **SS#:** _____ **BIRTHDATE:** _____

SECONDARY INSURANCE CO: _____ **ID.#:** _____ **EMPLOYED BY:** _____

INSURED'S NAME: _____ **SS#:** _____ **BIRTHDATE:** _____

PLEASE LIST UNION (IF APPLICABLE): _____

DENTAL HISTORY

Patient's Dentist: _____ Date of Last Visit: _____

1. Have there been any injuries to the face, mouth, or teeth? ☐YES ☐NO
2. Have you had or do you presently have any of the following habits?
   ☐Thumb or finger sucking ☐Lip Biting ☐Snoring ☐Grinding of teeth at night ☐Mouth breathing
3. Have you been informed of any missing or extra permanent teeth? ☐YES ☐NO
4. Are you aware of sores, lumps or irritated areas in the mouth? ☐YES ☐NO
5. Has an orthodontist been consulted previously? ☐YES ☐NO
   Name: _____ Date: _____
6. Have you ever been treated for: ☐Bad Bite ☐TMJ ☐Periodontal disease
   If so, by whom?: _____
7. Do you have any speech problems? ☐YES ☐NO
8. Are you frightened or anxious about Orthodontic treatment? ☐YES ☐NO
9. Are you concerned about the appearance of your teeth? ☐YES ☐NO
10. Is there anything you would like to change about your smile? ☐YES ☐NO
    If so, what?: _____
11. What aspect of dental treatment are you most concerned with? ☐Quality ☐Cost ☐Discomfort ☐Time
12. Reason for consultation (chief concern): _____
13. Has there ever been any orthodontic treatment for any other member of your family? ☐YES ☐NO Stage of TX: _____
    Were they satisfied with the results? ☐YES ☐NO

Sons (Dr._____) Daughters (Dr._____) Brothers (Dr._____) Sisters (Dr._____)

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MEDICAL HISTORY - ADULT

		COMMENTS
1. Is your general health good at this time?	☐YES ☐NO	
2. Are you under the care of a physician at this time?	☐YES ☐NO	
Explain:		
3. What is the name of your family physician?	Date of last physical:	
4. Are you taking any medication?	☐YES ☐NO	
Name:		
5. Are you allergic to any medication?(Penicillin, Sulfa, etc)	☐YES ☐NO	
Name:		
6. Have you ever had a serious illness or been hospitalized?	☐YES ☐NO	
Explain:		
7. Have you ever had your tonsils and/or adenoids removed?	☐YES ☐NO	
Age:		
8. Do you have any special problems not listed?	☐YES ☐NO	
Explain:		
9. Have you ever been advised by your physician to take an antibiotic prior to any dental treatments?	☐YES ☐NO	
If yes, antibiotic name and method:		
10. WOMEN:		
Are you pregnant or considering pregnancy during the next 2 years?	☐YES ☐NO	
Are you nursing?	☐YES ☐NO	
Are you currently taking medication for birth control?	☐YES ☐NO	

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

						MEMO
TUBERCULOSIS	☐YES ☐NO	RESPIRATORY LUNG DISEASE	☐YES ☐NO	FAINTING SPELLS	☐YES ☐NO	
ENDOCARDITIS	☐YES ☐NO	HIGH BLOOD PRESSURE	☐YES ☐NO	ADD/ADHD	☐YES ☐NO	
HEART CONDITION	☐YES ☐NO	LOW BLOOD PRESSURE	☐YES ☐NO	KIDNEY TROUBLE	☐YES ☐NO	
HEART PACEMAKER	☐YES ☐NO	HEPATITIS(type?_____)	☐YES ☐NO	LIVER DISEASE	☐YES ☐NO	
HEART ANGINA	☐YES ☐NO	VENEREAL DISEASE	☐YES ☐NO	PSYCHIATRIC		
HEART ATTACK(CORONARY)	☐YES ☐NO	HERPES(ORAL-COLD SORES)	☐YES ☐NO	TREATMENT	☐YES ☐NO	
MITRAL VALVE PROLAPSE	☐YES ☐NO	BLOOD DISORDERS/BLEEDING		DRUG ADDICTION	☐YES ☐NO	
CONGENITAL HEART DISEASE	☐YES ☐NO	PROBLEMS	☐YES ☐NO	HEADACHES	☐YES ☐NO	
ARTIFICIAL HEART VALVE	☐YES ☐NO	INFLAMMATORY RHEUMATISM	☐YES ☐NO	EARACHES	☐YES ☐NO	
HEART SURGERY; date:	☐YES ☐NO	ARTHRITIS	☐YES ☐NO	JAW CLICKING	☐YES ☐NO	
HEART MURMUR	☐YES ☐NO	ULCERS	☐YES ☐NO	ALLERGIES	☐YES ☐NO	
RHEUMATIC FEVER	☐YES ☐NO	STROKE	☐YES ☐NO	ALLERGIES TO METAL	☐YES ☐NO	
PROSTHETIC(artificial)JOINT	☐YES ☐NO	ANEMIA	☐YES ☐NO	TONSILLITIS	☐YES ☐NO	
X-RAY/RADIATION(cancer)THERAPY	☐YES ☐NO	ASTHMA	☐YES ☐NO	EMOTIONAL PROBLEMS	☐YES ☐NO	
AIDS OR H.I.V. POSITIVE	☐YES ☐NO	EPILEPSY	☐YES ☐NO	BLOOD TRANSFUSION	☐YES ☐NO	
DIABETES	☐YES ☐NO	GLAUCOMA	☐YES ☐NO	OTHER:_____	☐YES ☐NO	

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION. I grant authority to the Doctor and Staff to perform all procedures and treatments in my best interest. I understand (when appropriate) Credit Bureau reports may be obtained.

IN CASE OF EMERGENCY, CONTACT Name: _____ Phone: _____

Signature of Patient: _____ Date: _____ Signature of Orthodontist: _____