STRAIGHT SMILES ORTHODONTICS

259-19 Hill Side Ave.Floral Park, New York 11004
718.343.3411 • info@straightsmilesny.com

Patient Name: _____ Pat. # _____ Birth Date: _____ Age: _____

■ Child ■ Male ■ Female ■ Married ■ Single ■ Other _____

Social Security No.: _____-____-_____ E-Mail Address: _____

Home Phone No.: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext._____ Cell: (_____) _____-_____

Address: _____
Street Apt. City State Zip Code

Name of Parent/Legal Guardian: _____

Who referred you to us: _____

Dr. Notes

Are you in good health? _____
Have you been hospitalized or had a serious illness in the last five years?
If yes, please explain:
_____

Date of last medical exam:___/____/____ Date of last dental exam:___/____/____

Have you had problems with previous dental treatment?_____

Chief,Complaint:

_____

Please check the appropriate answers (leave blank if you do not understand the question).

YES	NO		YES	NO		YES	NO	
■	■	Chest Pain	■	■	Dizziness	■	■	Heart Attack, Heart Defects
■	■	Shortness of Breath	■	■	Headaches	■	■	Tumors, Cancer
■	■	Persistent Cough	■	■	Fainting Spells	■	■	Rheumatic Fever
■	■	Sinus Problems	■	■	Blurred Vision	■	■	Stroke
■	■	Seizures, Epilepsy	■	■	Frequent Urination	■	■	TB, Emphysema
■	■	Dry Mouth	■	■	Joint Pain, Stiffness	■	■	Diarrhea, Constipation, Blood in Stools
■	■	Frequent Vomit, Nausea	■	■	Heart Disease	■	■	Heart Murmurs/Mitral Valve Prolapse
■	■	Jaundice	■	■	AIDS, HIV Infection	■	■	Diabetes
■	■	Thyroid	■	■	STD			
■	■	Do you have any other diseases or medical problems not listed? _____						

Please check the appropriate answers (leave blank if you do not understand the question).

YES	NO		YES	NO		YES	NO	
■	■	Pre-medicated prior to dental visit	■	■	Mouth Breathing	■	■	Are you Pregnant or Nursing
■	■	Happy with the appearance of teeth	■	■	Pain/Clicking in Jaw	■	■	Are you taking birth control
■	■	Tooth Grinding/Jaw Clenching	■	■	Thumb Sucking			
■	■	History of Speech Problems	■	■	Tobacco, in any form			
■	■	Periodontal/Gum Problems	■	■	Alcohol			

Please check allergies:
- ■ Latex
- ■ Metal
- ■ Penicillin
- ■ Food
- ■ Medications

Please list all medications and supplements you are using: _____

_____

Please list metal, food or medications you are allergic to: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dental provider of any changes in my health and medication. I consent to an examination (to include x-rays).

X _____ _____

Signature of Responsible Party Date Signature of Doctor Date