Oran Pachter, D.M.D., P.C.
Pachter Orthodontics

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Patient's Clinical History/ Family Information: CONFIDENTIAL

(Please Complete in ink)

Todays Date_________

NAME____ BIRTHDATE__________________ Gender: ☐ Male ☐ Female

ADDRESS (Mailing) ______________________________________ CITY________________________ STATE________ ZIP____________

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Dr. HOME PHONE_____________________ CELL PHONE______________________

Appointment Reminders: Text Message # ____________________________ and/ or E-Mail ____________________________________

WHOM MAY WE THANK FOR REFERRING YOU?____

EMPLOYER_____________________________ OCCUPATION_____________________________ WORK PHONE__________________

BUSINESS ADDRESS____

S.S.#_________________________________

(For accounting purposes only)

CLOSEST RELATIVE

SPOUSE OR RELATIVES **NAME** ____ Relationship to patient ________________________

HOME ADDRESS_________________________________ CITY________________________ STATE_________ ZIP____________

HOME PHONE____________________ CELL PHONE _____________________ WORK PHONE _____________________

DENTAL INSURANCE INFORMATION ONLY

***Insurance can only be verified with a Social Security number and Date of Birth**

NAME OF INSURED____RELATIONSHIP TO PATIENT__________________________

BIRTHDATE_____________________ SOCIAL SECURITY NUMBER___________________________ DATE EMPLOYED____________

NAME OF EMPLOYER ____ WORK PHONE______________________________________

ADDRESS OF EMPLOYER _________________________ CITY____________________ STATE______________ ZIP _______________

INSURANCE COMPANY____________________________ GROUP #________________ UNION OR LOCAL # ____________________

INS. CO. ADDRESS_______________________________ CITY_____________________STATE______________ZIP _______________

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____ YES_____ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED____RELATIONSHIP TO PATIENT__________________________

BIRTHDATE_________________________ SOCIAL SECURITY NUMBER_____________________ DATE EMPLOYED______________

NAME OF EMPLOYER ____ WORK PHONE______________________________________

ADDRESS OF EMPLOYER _________________________ CITY____________________ STATE______________ ZIP _______________

INSURANCE COMPANY____________________________ GROUP #________________ UNION OR LOCAL # ____________________

INS. CO. ADDRESS_______________________________ CITY_____________________STATE______________ZIP _______________

PATIENT'S NAME____

PATIENT'S DENTIST______________________ Phone___________________ Address_______________________________

PATIENT'S PHYSICIAN____________________ Phone___________________ Address_______________________________

PATIENT MEDICAL HISTORY

		YES	NO
1.	Are you under medical treatment now?	___	___
2.	Have you ever been hospitalized for any surgical operation or serious illness?	___	___
3.	Are you taking any medication(s) including Non-prescription medicine?	___	___
	If yes, what medication(s) are you taking?____________________		
4.	Do you use tobacco?	___	___
5.	Do you use alcohol, cocaine or other drugs?	___	___
6.	Are you wearing contact lenses?	___	___

7. Are you allergic to or have you had any reactions to **medications, latex** or **metals**?
(Eg: aspirin, penicillin, sulfa drugs, etc.) If yes,what?________________

8. Women ONLY:	Yes	No
a) Are you pregnant or think you may be pregnant?	___	___
b) Are you nursing?	___	___
c) Are you taking birth control pills?	___	___

*Please comment any other significant information about the patient's medical history:____

8. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
( )	( )	High blood pressure	( )	( )	Heart Disease	( )	( )	Chest Pains
( )	( )	Heart Attack	( )	( )	Cardiac Pace maker	( )	( )	Easily Winded
( )	( )	Rheumatic Fever	( )	( )	Heart Murmur	( )	( )	Stroke
( )	( )	Swollen Ankles	( )	( )	Angina	( )	( )	Hay Fever / Allergies
( )	( )	Fainting/ Seizures	( )	( )	Frequently Tired	( )	( )	Tuberculosis
( )	( )	Asthma	( )	( )	Anemia	( )	( )	Radiation Therapy
( )	( )	Low Blood Pressure	( )	( )	Emphysema	( )	( )	Glaucoma
( )	( )	Epilepsy/ Convulsions	( )	( )	Cancer	( )	( )	Recent Weight Loss
( )	( )	Leukemia	( )	( )	Arthritis	( )	( )	Liver Disease
( )	( )	Diabetes	( )	( )	Joint Replacement or implant	( )	( )	Heart Trouble
( )	( )	Kidney Diseases	( )	( )	Hepatitis/ Jaundice	( )	( )	Respiratory Problems
( )	( )	AIDS or HIV Infection	( )	( )	STD	( )	( )	Other_____________
( )	( )	Thyroid Problem	( )	( )	Stomach Troubles/ Ulcers			

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	___	___
2. Are your teeth sensitive to hot or cold liquids/foods?	___	___
3. Are your teeth sensitive to sweet or sour liquids/foods?	___	___
4. Do you feel pain to any of your teeth?	___	___
5. Do you have any sores or lumps in or near your mouth?	___	___
6. Have you had any head, neck, or jaw injuries?	___	___
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking	___	___
b) Pain (joint, ear, side of face)?	___	___
c) Difficulty in opening or closing?	___	___
d) Difficulty in chewing?	___	___

	YES	NO
8. Do you have frequent headaches?	___	___
9. Do you clench or grind your teeth?	___	___
10. Do you bite your lips or cheeks?	___	___
11. Have any wisdom teeth been removed? How many?	___	___
12. Have you had any orthodontic work?	___	___
If yes, when_____________________________		
If yes, doctor's name_____________________________		
13. Have you ever had treatment for a periodontal disease (gum disease)?	___	___
14. Have your jaws ever "locked" CLOSED? If yes, describe__________________________	___	___
15. Have your jaws "locked" wide OPEN? If yes, describe__________________________		

GROWTH AND DEVELOPMENT

YES	NO	
___	___	Are there any learning disabilities? If yes, explain__________________________________
___	___	Has any other member of the family had orthodontic treatment?__________________________
___	___	Has any other member of the family been a patient in this office? Name:__________________

Please describe why you sought this consultation____

....

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

____ ___________________________

(Signature of Responsible Adult) Date

Doctor'sNotes____

____

____

____ Date:________________ Signature:______________________