cht orthodontics

CARRIE H. THANGAMANI, DDS, MS

Patient Information

DATE _____

PATIENT

Name _____ What would you like us to call you? _____

Birth date _____ Age _____

Address _____ City _____ Zip Code _____

Drivers License Number _____

Phone (Home) _____ (Cell) _____

Employer's Name _____ (Work) _____

Employer's Address _____ Occupation _____

Insurance Coverage **Yes** **No**

If insurance information is to be processed

Name of Insured _____ *Name of insurance company* _____

Date of Birth _____ *SS#* _____

GROUP# _____ *Occupation* _____

Dentist _____

Address _____ Phone Number _____

_____ Date of last checkup _____

Physician _____

Address _____ Phone Number _____

_____ Date of last checkup _____

Whom may we thank for referring you to this office? _____

Have you had previous orthodontic treatment? Please provide approximate dates _____

Brief summary of your previous treatment _____

_____

Retainer types and dates worn _____

How can we help you today? _____

_____ _____

_____ _____

_____

Where would you like us to confirm future appointments? Please circle below or provide information requested.

Home Phone Work Phone Cell Phone

Email address:_____

PLEASE ANSWER HEALTH HISTORY QUESTIONS ON OTHER SIDE

Patient Name _____ Date _____

	No	Yes
1. Are you under a doctor's care at the present time?		
2. Are you presently taking any medication regularly?		
3. Have you ever been told you have a heart condition (angina pectoris, heart murmur, etc.)?		
4. Have you ever been told that your blood pressure is too high or too low?		
5. Have you ever had rheumatic fever or rheumatic heart disease?		
6. Do you bleed excessively following a cut or other injury?		
7. Are you allergic to any food, drug, or medicine?		
8. Do you have other allergies such as hayfever or asthma?		
9. Have you ever been treated for diabetes?		
10. Have you ever been treated for epilepsy?		
11. Have you ever been diagnosed with or treated for ADD, ADHD, OCD, Bipolar Disorder or any behavioral disorder?		
12. Have you ever taken Cortisone, ACTH, or other steroid drug?		
13. Have you ever had a blood disease?		
14. Have you ever had a bone disease, or are you being treated for low bone density? If so, please list medication below		
15. Have you ever had a tumor or cancer?		
16. Have you ever had surgery?		
17. Have you had your tonsils and adenoids removed?		
18. Have you ever had a disease of the eyes, ears, nose, or throat?		
19. Have you had a recent weight gain or loss?		
20. Have you ever experienced prolonged bleeding following a tooth extraction or oral surgery?		
21. Have you ever experienced difficulty when dental anesthetics (Novocain) were administered?		
22. Have you been diagnosed with AIDS or AIDS related complex?		
23. Have you had any serious illness other than those mentioned?		
24. Have you had any accidents or injuries relating to your face, teeth, or head?		
25. Do you have any root canals, crowns, or dental implants?		
26. Have you ever had any other oral habits (nail biting, lip biting, cheek biting, etc.)?		
27. Do you grind or clench your teeth?		
28. Do you wear a night guard, and if so, what type?		
29. Have your wisdom teeth been extracted? Have any other teeth been extracted?		
30. Do you have any other information you would like us to be aware of to serve you best?		
31. Ever had: Pain in your jaw joint when opening, chewing, or yawning?		
a. Limited jaw movement?		
b. Clicking or popping noises in your ears while chewing?		
c. Your jaw get stuck open or closed?		
32. Do you play any sports regularly?		

Please sign and date _____

Thank you.