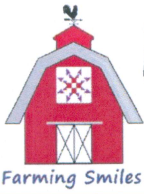

Panucci Orthodontics

5800 Willow Bend Road, Union, WV 24983
304-772-3707

Welcome to Our Office!

Patient Information

Date: ____________

Patient Name: ______________________________
Last First Middle

Address: ______________________________
Street City State Zip

Birthdate: __________ Social Security#: __________ Email Address: __________

Cell Phone #: __________ Home # (if not cell#): __________ Work Phone: __________

Employer: ______________________________ Occupation: __________

Marital Status (Circle One): Single Married Divorced Widowed Separated Partnered

Spouse's/ Partner Name: ______________________________ Birthdate: __________

Cell#: __________ Work #: __________ Email Address: __________

Employer: ______________________________ Occupation: __________

Children: ______________ Birthdate: __________ Age: ______ Male or Female

______________ Birthdate: __________ Age: ______ Male or Female

______________ Birthdate: __________ Age: ______ Male or Female

______________ Birthdate: __________ Age: ______ Male or Female

List any family members who have been or are in treatment in our office: __________

Whom may we thank for referring you to our office? __________

Hobbies:

Dental Insurance Information

Insured's Name: ______________________________ Social Security Number: __________
Last First Middle

Relationship to Patient: ______________________________ Birthdate: __________

Insured's Employer: ______________________________ Work Phone: __________

Insurance Company: ______________________________ Group Number: __________

Insurance Phone #: ______________________________

Do you have dual insurance coverage? Yes or No If Yes:

Insured's Name: ______________________________ Social Security Number: __________
Last First Middle

Relationship to Patient: ______________________________ Birthdate: __________

Insured's Employer: ______________________________ Work Phone: __________

Insurance Company: ______________________________ Group Number: __________

Insurance Phone #:

Emergency Information

Name of nearest relative not living with you: ______________________________

Relationship to patient: __________ Home phone: __________ Cell phone: __________

Address: ______________________________
Street City State Zip

Panucci Orthodontics

What main concerns do you want to address with orthodontic treatment? ______________________

____

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

Name of general dentist: ______________________ Date of last dental visit: ____________

Do you require antibiotic premedication before dental procedures? Yes No

Have you ever experienced any of the following?

Y N Clenching/Grinding	Y N Speech Problems	Y N Thumb/Finger Sucking Until what age? ______
Y N Tongue Thrust	Y N Mouth Breathing	Y N Pacifier Habit Until what age? ______
Y N Lip Sucking/Biting	Y N Nail Biting	Y N Experience Frequent Headaches

Have there been any injuries to the face, mouth, teeth or chin? Yes No

Descreibe if yes: ______________________________

List any instruments played: ______________________________

Have you been informed of any missing, impacted or extra permanent teeth? Yes No

Describe if yes: ______________________________

Have you had any pain/tenderness/noises in your jaw joint (TMJ/TMD), ears, temples or cheeks? Yes No

Describe if yes: ______________________________

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding	Y N Cancer	Y N Heart Murmur/Heart Problems	Y N Rheumatic/Scarlet Fever
Y N ADD/ADHD	Y N Diabetes	Y N Hemophilia	Y N Tuberculosis
Y N Anemia	Y N Epilepsy/Convulsions	Y N Hepatitis/Jaundice	Y N Tonsillitis/Adenoiditis
Y N Arthritis	Y N Endocrine Problems	Y N Herpes	
Y N Artificial Joints/Valves	Y N Emotional Problems	Y N HIV/AIDS	Y N Tonsils Removed:
Y N Asthma	Y N Frequent Colds or Flu	Y N Kidney/Liver Problems	Age: ______
Y N Blood Disease	Y N Handicaps/Disabilities	Y N Lupus	Y N Adenoids Removed:
Y N Bone Disorders	Y N Hearing Impairment	Y N Mitral Valve Prolapse	Age: ______
Y N Osteoporosis			

If answered yes to any above, please explain: ______________________________

____

Physician: ______________ Phone: ______________ Date last visit: ____________

Are you cuurently under the care of a physician? Yes No

Describe if yes: ______________________________

Please list all medications that you are currently taking: ______________________________

____

Please list all drugs/materials that you are allergic or sensitive to: ______________________________

____

* I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.
* I authoize the dental staff to perform the necessary dental services, including x-rays, I may need.

____

Signature of Patient **Date**

HEALTH HISTORY UPDATES

Date Reviewed	Reviewed By	List ANY Changes To This Form
______	______	______________________

Specialist In Orthodontics For Adults & Children