



PATIENT'S PERSONAL INFORMATION (please fill in all applicable items)

Patient's Full Name _____ Preferred firstname _____ SSN # _____
First, Middle, Last

Patient's Address _____ How Long? _____
Street, Apt # City State Zip

Home Phone(____) _____ Home FAX (____) _____ Email Address _____

Marital Status (if applicable) Single Married Divorced Separated Widowed

Employer or School/Grade _____ Phone(____) _____ - _____

Emergency Contact _____ Relationship _____ Phone(____) _____ - _____

Contact's Address _____

Whom may we thank for referring you? _____

Names and Ages of Children or Siblings _____

PRIMARY PERSON RESPONSIBLE FOR ACCOUNT

Full Name _____ Preferred firstname _____ Relation to Patient _____
First, Middle, Last

Home Address _____

Date of Birth ____/____/____ Home Phone(____) _____ Home FAX (____) _____

Marital Status Single Married Divorced Separated Widowed

SSN: _____ - _____ - _____ Employer: _____ Occupation _____

Work Phone: (____) _____ Email address: _____

SECONDARY PERSON RESPONSIBLE FOR ACCOUNT

Spouse Other Parent

Full Name _____ Preferred firstname _____ Relation to Patient _____
First, Middle, Last

Home Address _____

Date of Birth ____/____/____ Home Phone(____) _____ Home FAX (____) _____

Marital Status Single Married Divorced Separated Widowed

SSN: _____ - _____ - _____ Employer: _____ Occupation _____

Work Phone: (____) _____ Email address: _____

INSURANCE INFORMATION (If you have insurance, please complete this section)

Primary Dental Insurance Carrier (name,address) _____

Phone # () _____ Subscriber/Policy Holder's Name _____

SSN # _____ - _____ - _____ Group # _____ I.D.# _____ Relationship to Patient _____

Is orthodontic coverage available? Yes No

Signature of Ins. Holder releasing benefits to Dr. S. G. Papandreas _____

Secondary Dental Insurance Carrier (name,address) _____

Phone #() _____ Subscriber/Policy Holder's Name _____

SSN # _____ - _____ - _____ Group # _____ I.D. # _____ Relationship to Patient _____

PATIENT'S HEALTH INFORMATION

Patient's Full Name: _____ Male Female
 Date of Birth: ____/____/____ Age: ____ - ____
Years Months

Patient's Current or Last Dentist(s): _____ Approx. Month/Year of Last Visit ____/____
 Patient's Current or Last Pediatrician(s): _____ Approx. Month/Year of Last Visit ____/____
 Patient's Current or Last Physician(s): _____ Approx. Month/Year of Last Visit ____/____

Please list your concerns (most to least) _____
 Please list your goals of treatment _____
 Do you have any problems chewing food? Describe _____
 Have you ever had any injuries or blows to your face, jaws, mouth, or teeth? Describe _____
 List all current medications including non-prescription _____
 List all drug allergies _____
 List all previous surgeries or hospitalizations _____

Please questions below whose answer is "yes" for the patient (additional space below to describe, if necessary)

| | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Subject to prolonged bleeding or easy bruising | <input type="checkbox"/> Presently under the care of a physician (list who and why below) |
| <input type="checkbox"/> Chest pains or heart attack | <input type="checkbox"/> Contact lens wearer | <input type="checkbox"/> Treated for or told you have gum problems, bleeding gums |
| <input type="checkbox"/> Other heart troubles, murmur or mitral valve prolapse | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Had instructions on plaque control |
| <input type="checkbox"/> Shortness of breath or swollen ankles | <input type="checkbox"/> Epilepsy, convulsions, or seizures | <input type="checkbox"/> Brush your teeth three times daily |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Psychiatric therapy, emotional problems | <input type="checkbox"/> Floss your teeth daily |
| <input type="checkbox"/> Prosthetic devices (heart valve, hip, etc) | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Bad breath or unpleasant tastes in your mouth |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Do you have HIV (AIDS) | <input type="checkbox"/> Fever blisters or mouth sores |
| <input type="checkbox"/> Any lung disease (TB, emphysema, etc.) | <input type="checkbox"/> Exposed to/or tested for HIV (AIDS) | <input type="checkbox"/> Consulted for or had orthodontic treatment |
| <input type="checkbox"/> Asthma, allergies, hay fever | <input type="checkbox"/> Pregnant or possibly pregnant | <input type="checkbox"/> Other family members who have had orthodontic treatment or problems |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Taking birth control pills | <input type="checkbox"/> Had oral surgery |
| <input type="checkbox"/> Tonsils or adenoids removed | <input type="checkbox"/> Drink coffee daily | <input type="checkbox"/> Dental x-rays in the last year |
| <input type="checkbox"/> Mouthbreathing or excessive snoring | <input type="checkbox"/> Smoke or chew tobacco | <input type="checkbox"/> Missing or extra adult teeth |
| <input type="checkbox"/> Ulcers or other stomach problems | <input type="checkbox"/> Consume alcoholic beverages | <input type="checkbox"/> Teeth extracted. When? |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain, popping, catching or locking in jaw joints | <input type="checkbox"/> Sore teeth |
| <input type="checkbox"/> Hepatitis or other liver disease | <input type="checkbox"/> Clench or grind your teeth | <input type="checkbox"/> Tooth sensitivity (hot, cold, sweets) |
| <input type="checkbox"/> Kidney or bladder disease | <input type="checkbox"/> Awaken with sore jaws | <input type="checkbox"/> Suck thumb, finger, or lip. (current or past) |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Headaches more than once a week | <input type="checkbox"/> Tongue thrusting habit |
| <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Dizziness, ringing, or pain in ears | <input type="checkbox"/> Any wind instruments played |
| <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> Tenderness, stiffness in jaw, neck, back | <input type="checkbox"/> Excessive fear of dental treatment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Previous TMJ (jaw joint) problems and/or therapy | <input type="checkbox"/> Place a high priority on keeping your natural teeth |

Please expand on the above information (refer to letter or number) or add anything you feel is important _____

The above information is accurate and complete to the best of my knowledge:

Patient or Guardian's signature _____ Date ____/____/____ Patient or Guardian's signature _____ Date ____/____/____

Updated ____/____/____, P or G's Initials: _____

Updated ____/____/____, P or G's Initials: _____