John M. Cross, D.M.D.
Prosthodontics, Cosmetic, Implant
& Restorative Dentistry

Aesthetic Dental Group

Our Caring. Our Commitment.
Your Dental Home.

Monika Chan, D.M.D., M.Sc.D.
Orthodontics for Children,
Adolescents and Adults

NEW PATIENT WELCOME QUESTIONNAIRE

WELCOME _____

Our practice is here to provide our patients with the best orthodontic treatment available today. But our patients are also our friends!
If you would like, please answer these questions so that we may get to know you better.

What name or nickname do you like to be called by? _____

Are you originally from this area? If not, where are you from?

_____

What kind of music do you like? Who are your favorite performers?

_____

What type of books or movies do you like? _____

What type of sports do you like? _____

Do you have any pets? What kind? _____

What is your favorite subject (if in school)? _____

What are your hobbies? Do you like to collect anything?

_____

What else do you like to do with your spare time? _____

_____

Please finish this sentence. "I think getting braces would be . . . .

_____."

Do you have any friends or family who come to our office? Please list their names here.

_____

Thank you!

1794 Washington Valley Road • Martinsville, NJ 08836 • Phone 732-356-5050 • Fax 732-356-8691
info@aestheticdentalgrp.com • www.aestheticdentalgrp.com

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ORTHODONTIC INSURANCE INFORMATION

Please complete **BOLD** areas!

Name of Insurance Company _____

Insurance Company Address _____

Telephone Inquiries # _____

Group # _____

Insured's Employer _____

Employer Address _____

Employer Telephone # _____

Employee Name _____ ***SSN*** _____

Insured DOB _____

Patient Name _____ ***DOB*** _____

TO BE FILLED OUT BY THE OFFICE

Orthodontic Insurance Coverage: yes_____ no_____

Amount of Coverage: LTM_____ Deductible_____

Percentage Paid_____ Waiting Period: yes_____ no_____

Age_____ Coverage for minor tooth movement: yes_____ no_____

Early Interceptive treatment Coverage: yes_____ no_____

Predetermination needed: yes_____ no_____

Records Needed: yes_____ no_____

Payment Made: Annually____ Semi-Annually____ Quarterly_____ Monthly_____

Is a monthly adjustment statement required: yes_____ no_____

Electronic Submissions yes_____ no_____ Payor ID #_____

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American Association of
Orthodontists

CONFIDENTIAL

American Association of Orthodontists MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ I Prefer To Be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____

Patient's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Attends School At: _____ Grade: _____

Musical Instruments Played: _____

Sports And/Or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

Birth Father's Height _____ ft. _____ in. Birth Mother's Height _____ ft. _____ in.

Patient's Birth Weight _____ lbs. _____ oz. Patient's Present Weight _____ lbs. Height _____ ft. _____ in.

Custodial Parent(s) or Guardian(s): _____

Phone No. (if different than patient's): _____

Address (if different than patient's): _____

City: _____ State/Province: _____ Zip/Postal Code: _____

E-mail address: _____ Cell phone/pager: _____

Name of Patient's Dentist: _____ Phone No.: _____

Dentist's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Name of Patient's Physician(s): _____

Phone No(s): _____

Physician's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Who Is Financially Responsible For This Account?

Last Name: _____ First Name: _____ Middle Name/Initial: _____

Address (if different from patient's): _____

City: _____ State: _____ Zip: _____ Years at this address: _____

If less than five years, previous address: _____

City: _____ State: _____ Zip: _____

Phone No. (if different than patient's): _____ S.S.N/S.I.N.: _____

Employer: _____ How many years? _____

Insurance Coverage for Dental Treatment? Yes ☐ No ☐ Insurance Coverage for Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No.: _____

Medical Insurance Company: _____ Group No.: _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

☐yes ☐no ☐dk/u Does patient follow directions well?

☐yes ☐no ☐dk/u Does patient brush his/her teeth conscientiously?

☐yes ☐no ☐dk/u Does patient have learning disabilities or need extra help with instructions?

☐yes ☐no ☐dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, have you had:

☐yes ☐no ☐dk/u Birth defects or hereditary problems?

☐yes ☐no ☐dk/u Bone fractures, any major accidents?

☐yes ☐no ☐dk/u Rheumatoid or arthritic conditions?

☐yes ☐no ☐dk/u Endocrine or thyroid problems?

☐yes ☐no ☐dk/u Kidney problems?

☐yes ☐no ☐dk/u Diabetes?

☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?

☐yes ☐no ☐dk/u Stomach ulcer or hyperacidity?

☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?

☐yes ☐no ☐dk/u Problems of the immune system?

☐yes ☐no ☐dk/u AIDS or HIV positive?

☐yes ☐no ☐dk/u Hepatitis, jaundice or liver problem?

☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?

☐yes ☐no ☐dk/u Mental health disturbance or depression?

☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?

☐yes ☐no ☐dk/u Loss of weight recently, poor appetite?

☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?

☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

☐yes ☐no ☐dk/u High or low blood pressure?

☐yes ☐no ☐dk/u Tired easily?

☐yes ☐no ☐dk/u Chest pain, shortness of breath or swelling ankles?

☐yes ☐no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

☐yes ☐no ☐dk/u Skin disorder?

☐yes ☐no ☐dk/u Does the patient eat a well-balanced diet?

☐yes ☐no ☐dk/u Frequent headaches, colds or sore throats?

☐yes ☐no ☐dk/u Eye, ear, nose or throat condition?

☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble or hives?

☐yes ☐no ☐dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)

☐yes ☐no ☐dk/u Aspirin

☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)

☐yes ☐no ☐dk/u Penicillin or other antibiotics

☐yes ☐no ☐dk/u Sulfa drugs

☐yes ☐no ☐dk/u Codeine or other narcotics

☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)

☐yes ☐no ☐dk/u Latex (gloves, balloons)

☐yes ☐no ☐dk/u Vinyl

☐yes ☐no ☐dk/u Acrylic

☐yes ☐no ☐dk/u Animals

☐yes ☐no ☐dk/u Foods (specify) _____

☐yes ☐no ☐dk/u Other substances (specify) _____

☐yes ☐no ☐dk/u Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers, such as Zometa (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?

☐yes ☐no ☐dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate)? Please name the medication and length of time on the medication.

Medication _____ Length of time taken _____

Medication _____ Length of time taken _____

☐yes ☐no ☐dk/u Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

☐yes ☐no ☐dk/u Does the patient currently have or ever had a substance abuse problem?

☐yes ☐no ☐dk/u Does the patient chew or smoke tobacco?

☐yes ☐no ☐dk/u Operations? Describe: _____

_____

☐yes ☐no ☐dk/u Hospitalized? Describe: _____

_____

☐yes ☐no ☐dk/u Other physical problems or symptoms? Describe: _____

_____

_____

☐yes ☐no ☐dk/u Being treated by another health care professional?

For: _____

Date of most recent physical exam? _____

Are there any other medical conditions that we should be aware of?

_____

GIRLS ONLY

☐yes ☐no ☐dk/u Has the patient started her monthly periods?
If so, approximately when? _____

☐yes ☐no ☐dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Metabolic disturbances _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Any other family medical conditions that we should know about?

_____

DENTAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Started teething very early or late?

☐yes ☐no ☐dk/u Primary (baby) teeth removed that were not loose?

☐yes ☐no ☐dk/u Permanent or "extra" (supernumerary) teeth removed?

☐yes ☐no ☐dk/u Supernumerary (extra) or congenitally missing teeth?

☐yes ☐no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

☐yes ☐no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?

☐yes ☐no ☐dk/u Jaw fractures, cysts or mouth infections?

☐yes ☐no ☐dk/u "Dead teeth" or root canals treated?

☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?

☐yes ☐no ☐dk/u Periodontal "gum problems"?

☐yes ☐no ☐dk/u Food impaction between teeth?

☐yes ☐no ☐dk/u Thumb, finger, or sucking habit? Until what age_____?

☐yes ☐no ☐dk/u Abnormal swallowing habit (tongue thrusting)?

☐yes ☐no ☐dk/u History of speech problems?

☐yes ☐no ☐dk/u Mouth breathing habit, snoring or difficulty in breathing?

☐yes ☐no ☐dk/u Tooth grinding or jaw clenching?

☐yes ☐no ☐dk/u Any pain in jaw or ringing in the ears?

☐yes ☐no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?

☐yes ☐no ☐dk/u Difficulty encountered in chewing or jaw opening?

☐yes ☐no ☐dk/u Aware of loose, broken or missing restorations (fillings)?

☐yes ☐no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?

☐yes ☐no ☐dk/u Concerned about spaced, crooked or protruding teeth?

☐yes ☐no ☐dk/u Aware or concerned about under or over developed jaw?

☐yes ☐no ☐dk/u "Gum boils", frequent canker sores or cold sores?

☐yes ☐no ☐dk/u Taking any forms of fluoride?

☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?

☐yes ☐no ☐dk/u Had periodontal (gum) treatment?

☐yes ☐no ☐dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

☐yes ☐no ☐dk/u Any serious trouble associated with any previous dental treatment?

☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?

☐yes ☐no ☐dk/u Been under another dentist's care?

Specialist _____

Other _____

How often does your child brush: _____ floss: _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

_____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

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