DARYL YOREK DDS, MS SPECIALIST IN ORTHODONTICS & SLEEP MEDICINE

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

So that we might become better acquainted, please complete BOTH sides of this form.

Today's Date: _____/_____/_____ How did you hear about us? _____

Patient's Name		Birth Date: _____/_____/_____ Age: ____		
Address		Email		
FAMILY INFORMATION	**NAME**	Cell Phone	Work phone	Employer / occupation
Bio Father				
Bio Mother				
Step Father				
Step Mother				
Legal Guardian				

Who will be responsible for the account? What is your relationship to the patient?

INSURANCE INFORMATION

Subscriber's Name: _____
Relationship to Patient: _____
Date of Birth: _____
Social Security: _____
Dental Insurance Co.: _____
Group Number: _____
Insurance Phone: _____

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EMERGENCY CONTACT: **PHONE:**

Health Providers | Dentist: | Physician:

Please Tell us About Yourself	Where do you attend school or work?			
	What are your hobbies/interests?			
	How would you rate your smile? Worst (12345678910) Best Would you like whiter teeth? Yes / No			
Orthodontic Information	Is this your first visit to an orthodontist?	YES	NO	
	Are you interested in "Clear" braces?			
	Are you interested in Invisalign if feasible?			
	Do you have any dental or orthodontic concerns that affect you daily? How so?			
	What is your primary or greatest orthodontic concern?			
	What **results** are you are seeking from treatment?			
	What are you hoping to gain from today's exam?			
Dental Health	Are you current with your dentist?	YES	NO	UNSURE
	When was your last dental cleaning?			
	Did your dentist recommend an orthodontic evaluation?			
	Do you feel you grind or clench your teeth?			
	Has your dentist had to remove primary "baby" or permanent teeth?			
	Have you had any problems with your TMJ (jaw joint)?			
	Have you had any problems with periodontium (gums)?			
Habits	If you have any of these oral habits, when did this habit stop?	Date Stopped	Current Habit	Unsure
	Thumb/finger sucking?			
	Tongue Thrust?			
	Mouth breathing?			

MEDICAL HISTORY

	Please indicate if you have any of the following health concerns:	YES	NO	UNSURE
	Tonsils and/or Adenoids, removed? When?			
	Female: Are you pregnant, or planning a pregnancy?			
	Osteoarthritis or JRA (Juvenile Rheumatoid Arthritis)?			
	Gastrointestinal Disorders?			
	Asthma?			
	Replacement heart valve/joint or Rheumatic Fever?			
	Radiation and/or chemotherapy?			
	High or low blood pressure?			
	Blood transfusion or bleeding disorder?			
	Diabetes?			
	Emotional or psychological health concerns?			
	Depression and/or anxiety or panic attacks?			
	Hepatitis or liver diseases?			
	Any speech disorders or speech therapy?			
	HIV/Aids?			
	Is there any medical condition that we should be aware of? Please explain:			
Pain	Are you apprehensive about dental or orthodontic treatment?			
	Do you have facial pain?			
	Do you have head, neck or jaw pain?			
	Do you have had any trauma to the head, neck, or mouth?			
Sleep	Do you have difficulty with sleeping? Please explain,			
Airway	**Do you snore frequently?**	YES	NO	UNSURE
	Do you choke or stop breathing during sleep?			
	Do you have any personal history of Obstructive Sleep Apnea?			
	Any FAMILY history of (OSA) or other sleeping disorders?			
	Obstructive sleep apnea (OSA) is highly correlated with certain types of orthodontic malocclusions and related problems. Has your primary care provider or sleep physician discussed with you the health risks of OSA, as well as treatment options to to manage OSA?			
	Would you like to have more information for sleep apnea (OSA)?			
	Would you like to find out if you are at risk for obstructive sleep apnea (OSA)?			
Meds	Have you taken *"Bisphosphonase"* or *"Fosamax"* for osteoporosis or cancer*?*			
	Please list all medications you are currently taking	Dosage and frequency		
	1.			
	2.			
	3.			
	Do you have a LATEX allergy?	YES or NO		
	Do you have any drug allergies? If yes, please explain,			
Other	If you consume any of the following, please indicate below	Amount and frequency		
	1. Alcohol			
	2. Tobacco products			

Reviewing Tx Coordinator:		Date:

*A recent cleaning and check-up (within the last 6 months) will be necessary before orthodontic appliances can be placed. *

I have answered the above health and dental questions accurately and to the best of my ability and agree to update Dr Yorek of any health/dental changes. I authorize Daryl Yorek DDS, MS to perform an orthodontic evaluation.

Signature: _____ Date: _____

I herby acknowledge that a copy of this office's Notice of Privacy Practice's has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature: _____ Date: _____