Beach BRACES
orthodontics for all ages
Dr. Patti Panucci

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Patient's Personal Information (please complete all applicable items)

Patient's Full Name_____ Nickname (if preferred)_____ Date of Birth____/____/____

Patient's Address:_____
Street City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

E-mail address _____ Employer/School & Grade_____

Marital Status (if applicable): Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

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

Primary Person Responsible for Account

Full Name_____ Relation to Patient:_____

Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

E-mail address _____ SSN#_____ Date of Birth _____/_____/_____

Marital Status (if applicable): Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Employer: _____ Occupation: _____ How long?_____

Secondary Person Responsible for Account

Full Name_____ Relation to Patient:_____

Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

E-mail address _____ SSN#_____ Date of Birth _____/_____/_____

Marital Status (if applicable): Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Employer: _____ Occupation: _____ How long?_____

Insurance Information (If you have insurance, please complete this section.)

Name of Insured_____ ID#/SSN#_____ Date of Birth____/____/____

Primary Dental Insurance Carrier (Name & Address) _____

Insurance Company Phone: (_____) _____ Group #_____

Signature of insurance holder releasing benefits to Patricia J. Panucci, DMD, MS, APDC _____

Name of Insured_____ ID#/SSN#_____ Date of Birth____/____/____

Secondary Dental Insurance Carrier (Name & Address) _____

Insurance Company Phone: (_____) _____ Group #_____

Signature of insurance holder releasing benefits to Patricia J. Panucci, DMD, MS, APDC _____

At Beach Braces, our goal is to create smiles in more ways than one....everyday!

PLEASE TURN OVER AND COMPLETE REVERSE SIDE

Dental History

Why are you seeking an orthodontic consultation for you **or** your child? _____
_____

Y or N Have you **or** your child been treated by an orthodontist previously? (circle)
If yes, how long? _____ At what age? _____
Y or N Have you **or** your child consulted with an orthodontist recently? (circle)
Y or N Have you **or** your child ever had a serious/difficult problem with dental treatment? (circle)
Y or N Do you **or** your child clench or grind your teeth? (circle)
Y or N Is there a history of thumb or finger sucking? (circle) Until what age? _____
Y or N Is there a history of head, neck, or face injury? (circle) Explain. _____
_____
Y or N Do you **or** your child have speech problems or a tongue thrust? (circle)
Y or N Are you **or** your child a mouth breather? While awake or while asleep? (circle)
Y or N Have you **or** your child ever had any TMJ problems or TMJ pain? (circle)
Y or N Do you **or** your child experience frequent headaches? (circle)
Y or N Have adenoids or tonsils been removed? (circle)
Y or N Have you **or** your child been informed of missing or extra permanent teeth? (circle)
Y or N Do you **or** your child require antibiotics before dental treatment? (circle)
Dentist name _____ Last Appt. Date _____

Medical History

Please circle Y or N to the following:

Y or N	Arthritis	Y or N	ADD/ADHD	Y or N	Allergies to Drugs
Y or N	Allergy to Latex/Metals	Y or N	Allergic to Plastic	Y or N	Any Hospital Stays
Y or N	Any Operations_____	Y or N	Artifical Joints/Valves	Y or N	Asthma
Y or N	Anemia	Y or N	Blood Transfusion	Y or N	Cancer
Y or N	Convulsions/Epilepsy	Y or N	Congenital Heart Defect	Y or N	Diabetes
Y or N	Handicaps/Disability	Y or N	Hearing Impairment	Y or N	Heart Murmur
Y or N	Hepatitis	Y or N	HIV+ or AIDS	Y or N	Kidney Problems
Y or N	Herpes/Fever Blisters	Y or N	Liver Problems/Jaundice	Y or N	Lupus
Y or N	Emotional Problems	Y or N	Tuberculosis (TB)	Y or N	Abnormal Bleeding
Y or N	High Blood Pressure	Y or N	Heart Attack/Stroke	Y or N	Heart Surgery
Y or N	Mitral Valve Prolapse	Y or N	Radiation Treatment	Y or N	Shingles
Y or N	Sinus Problems	Y or N	Ulcers/Colitis	Y or N	Sickle Cell Disease
Y or N	Rheumatic/Scarlet Fever	Y or N	Venereal Disease	Y or N	Psychiatric Treatment

Are you **or** your child currently under the care of a physician? Y or N
Has puberty begun? Y or N
Has menstruation begun (girls)? Y or N
Have you **or** your child ever taken Fen-Phen (also known as Redux or Pondimin)? Y or N
Please list all medications you **or** your child are currently taking: _____
_____
Please list all medications, etc. that you **or** your child are allergic or sensitive to: _____
_____
Physician _____ Phone # _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my **or** my child's medical status. I authorize the dental staff to perform the necessary dental services that I **or** my child may need during diagnosis and treatment with my informed consent.

_____
Signature of adult patient or guardian **Date**

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with patient named herein.
Initials_____ Date_____ Comments:_____
_____