W. JERRY CAPPS, D.D.S., M.S.D.
JOHN IACULLI, D.D.S., M.S.

Name_____ Marital Status: S M D W Sex: M F
Last First Preferred

Spouse's Name_____ Birthdate_____
Last First Preferred

Referred by_____

Relatives or friends in the practice_____

Chief Complaint_____

How do you feel about orthodontic treatment?_____

----------Family History----------

Y N Anyone requiring orthodontic treatment? Who?_____
Y N Anyone with congenitally missing teeth?_____ Crowding?_____ Protruding teeth?_____
Y N Unusual dental problems? Please explain_____
Y N Anyone with a prominent jaw?_____ Small lower jaw?_____
Y N Anyone with Diabetes? **Y N** Arthritis? **Y N** Severe allergies? To what?_____
Any other family medical conditions that we should know about?_____

----------Dental History----------

Who is your Dentist?_____ For how long?_____ Date of last visit?_____
How often do you brush?_____ Floss?_____
Now, or in the past, have you had:

Y N Jaw fractures, cysts or mouth infections?
Y N Teeth sensitive to hot or cold; teeth throb or ache?
Y N Bleeding gums, bad taste or mouth odor?
Y N Tooth grinding or jaw clenching?
Y N Frequent headaches?
Y N Abnormal swallowing habit (tongue thrusting)?
Y N Periodontal "gum problems"
Y N Root canal treatment?
Y N Difficulty in chewing or jaw opening?
Y N Wisdom teeth problems?
Y N History of speech problems?
Y N Supernumerary or congenitally missing teeth?
Y N Mouth breathing habit, snoring or difficulty in breathing?
Y N Any aching, ringing, dizziness or fullness in your ears?
Y N A major accident or fall involving your head, face and /or teeth?
Y N Chipped or otherwise injured primary (baby) or permanent teeth?
Y N Permanent, primary (baby) or supernumerary (extra) teeth removed?
Y N Any pain, clicking or locking in jaw or ringing in the ears?
Y N Any pain or soreness in the muscles of the face or around the ears?
Y N Have you ever been treated for "TMD" or "TMJ" problems?
Y N Awareness of or concern about under-developed or over-developed jaw?
Y N Any relative with similar tooth or jaw relationships?
Y N Loose, broken or missing restorations (fillings)?
Y N Any teeth irritating cheek, lip, tongue or palate?
Y N Concern about spaced, crooked or protruding teeth?
Y N An orthodontic examination or treatment? Please explain _____

Continued. . . . . .

----------Medical History----------

Physician:_____ **Telephone number:**_____ **Last examination:**_____

Now, or in the past, have you had:

Y N Birth defects or hereditary problems?
Y N Bone fractures, any major accidents?
Y N Rheumatoid or arthritic conditions?
Y N Endocrine or thyroid problems?
Y N Kidney problems?
Y N Diabetes?
Y N High or low blood pressure?
Y N Tired easily?
Y N Frequent colds or sore throats?
Y N Hayfever, asthma, sinus trouble or hives?
Y N Osteoporosis?
Y N Polio, mononucleosis, tuberculosis, pneumonia?
Y N Vision, hearing or speech difficulties?
Y N Chest pain, shortness of breath or swelling ankles?
Y N Cancer, tumors, radiation treatment or chemotherapy?
Y N Fainting spells, seizures, epilepsy or neurological problem?
Y N Excessive bleeding or bruising tendency, anemia or bleeding disorder?
Y N Cardiovascular problem (heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart Defects, heart murmur or rheumatic heart disease)?
Y N Do you currently have or ever had a substance abuse problem?
Y N Do you chew or smoke tobacco?
Y N Operations? Describe:_____
Y N Hospitalized? Describe:_____
Y N Other physical problems or symptoms? Describe:_____
Y N Being treated by another health care professional? For:_____
Date of most recent physical exam?_____
Y N Are you currently taking any medication, nutrient supplements, herbal medications or non-prescriptions medicine? Please name them:
Medication:_____ Taken for:_____
Medication:_____ Taken for:_____
Medication:_____ Taken for:_____
Medication:_____ Taken for:_____
Medication:_____ Taken for:_____
Y N Have you ever had antibiotics prescribed for dental treatment? If so why?_____
Do you have any other medical conditions we should know about?_____

Y N Problems of the immune system?
Y N AIDS or HIV positive?
Y N Hepatitis, jaundice or liver problem?
Y N Mental health disturbance or depressions?
Y N Loss of weight recently, poor appetite?
Y N History of eating disorder (anorexia, bulimia)?
Y N Skin disorder?
Y N Eye, ear, nose or throat condition?
Y N Tonsil or adenoid conditions?
Y N Stomach ulcer or hyperacidity?
Y N Do you have a well-balanced diet?

Females only: **Y N** Are you pregnant?
Y N Are you anticipating becoming pregnant?

Do you have any allergies or reactions to the following:

Y N Local anesthetics (Novocaine or Lidocaine)?
Y N Aspirin?
Y N Ibuprofen (Motrin or Advil)?
Y N Penicillin or other antibiotics?
Y N Sulfa drugs?
Y N Codeine or other narcotics?
Y N Metals (jewelry, clothing snaps)?
Y N Latex (gloves, balloons)?
Y N Vinyl?
Y N Acrylic?
Y N Animals?
Y N Foods? (specify)_____
Y N Other substances? (specify)_____

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 records or medical/dental status, I will so inform this practice.

_____

Signature of patient Date

W. JERRY CAPPS, D.D.S., M.S.D.
JOHN D. IACULLI, D.D.S., M.S.

Date _____

Patient Information

Patient's Name _____

Home Address _____
City Zip

Home Phone _____ Email Address _____ Birthdate _____

Employer _____ Occupation _____ No. Of Years Employed _____

Employer Address _____ Work Phone _____

Social Security Number _____ Cell Phone _____

Spouse's Name _____

Address _____
City Zip

Home Phone _____ Work Phone _____ Birthdate _____

Employer _____ Occupation _____ No. of Years Employed _____

Employer Address _____ Social Security Number _____

Responsible Party (If different from Patient) _____

Address _____
City Zip

Home Phone _____ Work Phone _____ Social Security Number _____

Employer _____ Employer Address _____

Whom May We Thank For Referring You To Our Office? _____

Primary Orthodontic Insurance Information

Insured's Name _____ Insured's ID # _____ Insured's Date of Birth _____

Insurance Company _____ Group Number _____

Insurance Claims Address _____

Customer Service Telephone Number _____

Secondary Orthodontic Insurance Information

Insured's Name _____ Insured's ID # _____ Insured's Date of Birth _____

Insurance Company _____ Group Number _____

Insurance Claims Address _____

Customer Service Telephone Number _____

Emergency Information

Name Of Nearest Relative Not Living With You _____

Address _____ Phone Number _____