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

Name _____ Birthdate _____ Sex: M F
Last First Preferred
Mother's name _____ Marital Status: S M D W
Last First
Father's name _____ Marital status: S M D W
Last First
School _____ Grade _____
Progress: Good_____ Average_____ Below Average_____ Hobbies/sports/interests_____
Referred by _____
Relatives or friends in practice _____
How does patient feel about orthodontic treatment? _____
Reason for visit? _____

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

Age(s) of brother(s) _____ Ages(s) of sister(s) _____
Y N Did brother or sister require orthodontic treatment?
Y N Did either parent receive orthodontic treatment?
Y N Does either parent have congenitally missing teeth? **Y N** Crowding? **Y N** Protruding teeth?
Y N Does either parent have a prominent jaw? **Y N** Small lower jaw?
Y N Does patient have a habit of thumb/finger sucking? **Y N** Lip biting? **Y N** Nail biting?
Y N Do any of patients' parents or siblings have: **Y N** Diabetes? **Y N** Arthritis?
Y N Metabolic disturbances? **Y N** Severe allergies? To what? _____
Y N Unusual dental problems? If yes, please describe: _____
Other family medical conditions that we should know about? _____

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

Who is patient's Dentist? _____ For how long? _____ Date of last visit? _____
Now, or in the past, has the patient had:

Y N Supernumerary (extra) or congenitally missing teeth?
Y N Permanent or supernumerary (extra) teeth removed?
Y N Primary (baby) teeth removed that were not loose?
Y N Bleeding gums, bad taste or mouth odor?
Y N Abnormal swallowing habit (tongue thrusting)?
Y N Speech problems?
Y N Frequent headaches?
Y N Teeth sensitive to hot or cold; teeth throb or ache?
Y N Any pain in jaw or ringing in ears?
Y N Jaw fractures, cysts or mouth infections?
Y N Root canal treatment?
Y N Any periodontal (gum) treatment?
Y N Periodontal (gum) problems?
Y N Any teeth irritating cheek, lip, tongue or palate?
Y N Grinding of teeth or jaw clenching?
Y N Does patient brush conscientiously?
Y N Does patient floss regularly?
Y N Did patient start teething very early or very late?
Y N Mouth breathing habit, snoring or difficulty in breathing?
Y N A major accident/fall involving head, face and/or teeth?
Y N Any pain or soreness in the muscles of the face or around the ears?
Y N Difficulty encountered in chewing or jaw opening? Any clicking or popping of jaw joint?
Y N Loose, broken or missing restorations (fillings)?
Y N Concern about spaced, crooked or protruding teeth?
Y N Awareness or concern about under-developed or over-developed jaw?
Y N Any relative with similar tooth or jaw relationships?
Y N An orthodontic examination or treatment?
Y N Is patient currently under any stress or upset?

Continued.....

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

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

Now, or in the past, has the patient 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, tasting or speech difficulties?
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 Chest pain, shortness of breath or swelling ankles?
Y N Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
Y N Operations? Describe: _____
Y N Hospitalized? Describe: _____
Y N Other physical problems or symptoms? Describe: _____
Y N Does patient follow directions well?
Y N Does the patient currently have or ever had a substance abuse problem?
Y N Does the patient have learning disabilities or need extra help with instructions?
Y N Being treated by another health care professional? For: _____
Date of most recent physical exam? _____
Y N Is patient currently taking any medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them:
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____

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

Girls only: Y N Has the patient started her monthly periods**?** Approximately when? _____
Y N Is the patient 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 Parent or Guardian Date

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

DATE _____

Patient's Name _____
Last First Middle

Home Address _____
City Zip

Home Phone _____ Email Address _____ Date Of Birth _____

Mother _____ Phone: Day _____ Night _____

Father _____ Phone: Day _____ Night _____

Step-parent _____ Phone: Day _____ Night _____

Cell phone (Mom) _____ Cell phone (Dad) _____

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

Responsible Party Information

Name _____ Relationship To Patient _____
Last First M.I.

Address _____

Home Phone _____ Work Phone _____ Email Address _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____

Spouse's Name _____ Relationship To Patient _____
Last First M.I.

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Home Phone _____ Work Phone _____

Orthodontic Insurance Information

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

Insurance Company _____ Group Number _____

Insurance Claims Address _____

Custom Service Telephone Number _____ Insured's Employer _____

Secondary Insurance Information

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

Insurance Company _____ Group Number _____

Insurance Claims Address _____

Customer Service Telephone Number _____ Insured's Employer _____

Emergency Information

Name Of Nearest Relative Not Living With You _____

Address _____ Phone Number _____