Patient Information

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other:________________

Patient Name:____

First Middle Last (Name Called)

Birthday:________________

Home Phone:________________ Work Phone:________________

Address:____

Email Address:____

City, State Zip Code:____

Sex M ☐ F ☐ SSN:________________ Race:________________

Dentist:____

Physician____

Who referred you to our practice?____

Any Medical Problems?____

Responsible Party Information

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other:________________

Responsible Party Name:____

First Middle Last (Name Called)

Birthday:________________

Home Phone:________________ Work Phone:________________

Address:____

Address:____

City, State ZipCode:____

Sex M ☐ F ☐ SSN:________________ Relationship to Patient:________________

Is this Responsible Party Financially Responsible for Charges? yes ☐ no ☐

Is this the Primary Person who brings patient to appointments? yes ☐ no ☐

DENTAL Insurance Company:____

Member ID Number________________ Phone:________________

Address:____

Employer:____

Address:____

Additional Information

List Family Members that are currently in our practice:____

____

____

Other Information:____

____

____

Date: ____________________

MEDICAL / DENTAL HISTORY

IS PATIENT IN GOOD HEALTH? YES ☐ NO ☐ PATIENT'S PHYSICIAN ____________________

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

DIABETES ☐	TUBERCULOSIS ☐	ENDOCRINE PROBLEMS ☐	GLAUCOMA ☐
PNEUMONIA ☐	ANEMIA ☐	PROLONGED BLEEDING ☐	HEPATITIS ☐
HEART DISEASE ☐	EPILEPSY ☐	FAINTING OR DIZZINESS ☐	LIVER DISEASE ☐
RHEUMATIC FEVER ☐	ASTHMA ☐	NERVOUS DISORDERS ☐	ALCOHOL/DRUG DEPENDENCY ☐
BONE DISORDERS ☐	KIDNEY DISEASE ☐	IMMUNE DISORDERS ☐	OTHER ☐

DOES PATIENT HAVE TENDENCY TO: COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? ________ YES ☐ NO ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN ____________________

LIST ANY ALLERGIES OR DRUG SENSITIVITY ____________________

HAS THE PATIENT REACHED PUBERTY? (not applicable for Adults)

GIRLS - HAS SHE STARTED MENSTRUATION: .... YES ☐ NO ☐

BOYS - HAS HIS VOICE CHANGED? .... YES ☐ NO ☐

APPROXIMATE DATE OF LAST DENTAL EXAMINATION ____________________

HAVE THEIR BEEN ANY INJURIES TO THE FACE, MOUTH, OR TEETH .... YES ☐ NO ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? .... YES ☐ NO ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? .... YES ☐ NO ☐

SIGNATURE (Parent or guardian signature if minor) ____________________

(For office use only do not write below this line)

NAME ____________________ NICKNAME ____________________

CR-CO PIC ________

OPENING ________ DEVIATION ________

SOUNDS ________ PAIN ________

EDCBA	ABCDE	87654321	12345678
EDCBA	ABCDE	87654321	12345678

MOLAR ________ CUSPID ________

DIV. ________ CO CR

MIDLINE MX ________

MIDLINE MN ________

LIP POSTURE ________

LIP TONUS ________

__ O.H. ________

__ HABITS ________

__ INTEREST ________

__ CONG. ABS. ________

__ MALFORMED ________

__ PROFILE ________

GING. ATTACH ________

FRENA ________

O.J. MM ________

OOB. % ________

EST. FEE ________

EST. TIME ________

DX ____________________

TX OPTIONS ____________________

TOTAL ________

INITIAL ________

BALANCE ________

TX TIME ________

FEE OK ________ ALT ________

UNDECIDED ________

REASON ________

WILL CALL BY ________

CONTACT DATE ________

RESPONSE ________

DISPOSITION ________

Lovrovich

Exceptional credentials. Innovative capabilities. Beautiful smiles.

ORTHODONTICS

DENTAL QUESTIONNAIRE

PATIENT NAME: ____ Date:__________

TO ASSIST US IN UNDERSTANDING YOUR DENTAL CONDITION AND EXPERIENCES, WOULD YOU PLEASE ANSWER THE FOLLOWING QUESTIONS? IF YOU HAVE ANY DOUBTS ABOUT THE INFORMATION REQUESTED PLEASE ASK THE DOCTOR. PLEASE CHECK ANSWERS AS APPROPRIATE.

HAVE YOU EVER HAD THE FOLLOWING TREATMENT?

- ORTHODONTICS (STRAIGHTENING OF YOUR TEETH)...... YES___ NO___
  IF YES: AS A CHILD___ ADULT_____ WERE YOU: HAPPY____ UNHAPPY___
  WITH RESULT?
- EXTRACTIONS OF PERMENENT TEETH............... YES______ NO_______
  IF YES: HOW LONG AGO___________________ REASON FOR EXTRACTION
- PERIODONTAL TREATMENT(GUM TREATMENT).........YES______ NO______
  IF YES: HOW LONG AGO__________ DESCRIBE TREATMENT:
- MOUTHGUARD OR SPLINT (PLASTIC DEVICE BETWEEN YOUR TEETH........
  YES__________ NO _________
- TREATMENT OR SURGERY TO CHANGE YOUR BITE....YES_______ NO_______
- DENTAL IMPLANTS.................................. YES____________ NO_______
- PARTIAL DENTURES................................. YES____________ NO ______

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS:

- TRAUMA/BLOWS TO THE FACE OR JAWS YES_________ NO__________
- TRAUMA OR BLOWS TO THE TEETH YES_________ NO__________
- SORES,LUMPS,BLISTERS,OR IRRITATED AREAS IN YOUR MOUTH YES_________ NO_________
- SORE OR BLEEDING GUMS YES_________ NO__________
- LOOSE PERMANENT TEETH YES_________ NO__________
- MOUTH BREATHING HABIT SNORING OR DIFFICULTY BREATHING YES________ NO__________
- CHIPPED TEETH YES_________ NO__________
- SPEECH PROBLEMS YES_________ NO__________
- LOSS OF TEETH OR MISSING FILLINGS YES__________NO____________
- FREQUENT "DRY MOUTH" YES__________NO____________

(Over)

- THUMB OR FINGER SUCKING HABIT AS CHILD: YES_____ NO________
- ORAL HABITS: BITING ON PENS,NAIL BITING ETC YES_____ NO_________
- CLICKING,POPPING,OR GRATING NOISE IN JAW YES________ NO___________
- NUMBNESS OR TINGLING IN YOUR MOUTH OR FACE: YES_______ NO_______
- TENDER OR SENSITIVE TEETH:CLENCHING OR GRINDING:YES___ NO________
- PAIN OR FATIGUE IN YOUR JAWS OR FACE : YES_________ NO_____________
- LIMITATIONS IN OPENING OR MOVING YOUR LOWER JAW OR CHEWING: YES_________ NO_____________
- ROOT CANALS: YES_________ NO_____________
- OVER THE PAST FIVE YEARS, HOW OFTEN HAVE YOU BEEN SEEN FOR TEETH CLEANINGS? ______________________________
- THE DATE OF YOUR LAST CLEANING AND EXAM BY A DENTIST:_____________
  THAT DENTIST NAME______________________________
- ARE YOU FRIGHTENED OR ANXIOUS ABOUT DENTAL TREATMENT?
  YES__________________________ NO___________________________
- HAVE YOU HAD AN UNPLEASANT EXPERIENCE AT A DENTAL OFFICE? IF YES, WOULD YOU BE WILLING TO TELL US ABOUT IT SO WE AVOID A SIMIALR EXPERIENCE? YES______________________ NO_________________
- WOULD YOU CHANGE ANYTHING ABOUT YOUR TEETH OR SMILE?
  YES__________________ NO___________________________

  PLEASE EXPLAIN? ______________________________

- WHAT ASPECTOF DENTAL TREATMENT ARE YOU MOST CONCERNED WITH? IF MORE THAN ONE APPLIES, **PLEASE NUMBER 1-4 INORDER OF IMPORTANCE,** 1 BEING MOST IMPORTANT.

  QUALITY______ COST_______ DISCOMFORT_________ TIME___________

- PLEASE MAKE ANY ADDITIONS OR EXPLAIN ABOVE CONDITIONS AS APPROPRIATE______________________________

  ____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

We keep a record of dental healthcare services we provide you. You may ask to see and keep a copy of that record. You may also ask to correct the record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your dental information may be disclosed, and how you can access your information.

I acknowledge receipt of the Notice of Privacy Practices from Lovrovich Orthodontics, Anthony T. Lovrovich DDS., PS.

Patient of Legally Authorized Individual Signature: ______________________________

Printed Name (or if signed on behalf of the patient): ______________________________

Relationship: ____
(Parent, Legal Guardian, Personal Representative, Nanny)

Date: ________________________

This form will be retained in your medical records