Ortho

York Dental

Majdi I. Alrabady, DDS, BDS, FAGD
6390 York Rd, Parma Heights, OH 44130
(440) 884-2424, www.york-dental.com

Medical Alert:

Thank you for choosing us for your dental care! Please fill out all sections of this confidential form.
Your information is never shared and kept strictly confidential. If you have any questions or require assistance, please ask!

1. Patient Information

How did you hear about our office? _____

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

Status: ☐ Child ☐Single ☐Married ☐Divorced ☐Widowed **Gender:** ☐ Male ☐ Female

Patient Name: FIRST _____ MI_____ LAST_____

Address _____Apt_____ City _____ State _____ Zip _____

Birthdate: _____ Social Security Number: _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Employer _____ City _____ Occupation _____

Emergency Contact Person _____ Relation to Patient _____ Phone # _____

PHONE NUMBER where patient/guardian can be reached ***DURING THE DAY*:** ☐ Home ☐ Cell ☐ Work

2. Dental Insurance

Do you have dental insurance coverage? ☐ Yes ☐ No -- ***If no, skip to section 3.***

Primary Insurance Co._____ Phone _____ Address _____

Subscriber Name_____ Subscriber Birthdate _____ Subscriber SSN #: _____

Subscriber ID#_____ Group # _____ Employer/Group Name:_____

Secondary Insurance Co._____ Phone _____ Address _____

Subscriber Name_____ Subscriber Birthdate _____ Subscriber SSN #: _____

Subscriber ID#_____ Group # _____ Employer/Group Name:_____

3. (for Child/Dependent Patient) Responsible Party

Father's Name_____ ☐ Biological ☐ Other _____

Address _____Apt # _____City _____State:_____ Zip_____

Home Phone _____ Work Phone _____Cell Phone _____

Social Security Number _____ Birthdate _____

Employer _____Occupation _____

Mother's Name_____ ☐ Biological ☐ Other _____

Address _____Apt # _____City _____State:_____ Zip_____

Home Phone _____ Work Phone _____Cell Phone _____

Social Security Number _____ Birthdate _____

Employer _____Occupation _____

***** Person financially responsible for this account/ Phone number (if other than parents listed above)***

_____

(Please also complete the back of this form)

Patient First Name: _____ **Last Name:** _____ **DOB**_____

4. Personal Medical History (check Yes or No for medical conditions currently or in the past)

AIDS/HIV Positive ❑Yes ❑ No
Alcoholism ❑Yes ❑ No
Anemia ❑Yes ❑ No
Arthritis ❑Yes ❑ No
Asthma ❑Yes ❑ No
Bone Disease ❑Yes ❑ No
Cancer ❑Yes ❑ No
Type:_____
Chemical Dependency ❑Yes ❑ No
Chest Pain ❑Yes ❑ No
Circulatory Problems ❑Yes ❑ No
Convulsions/Seizures ❑Yes ❑ No
Diabetes ❑Yes ❑ No
Excessive Bleeding ❑Yes ❑ No
Epilepsy ❑Yes ❑ No
Frequent Headaches ❑Yes ❑ No
Hearing Impaired ❑Yes ❑ No
Heart Disease ❑Yes ❑ No
Heart Valve, Murmur ❑Yes ❑No
Hepatitis/Liver Disease ❑Yes ❑ No
Hepatitis Carrier ❑Yes ❑ No
High Blood Pressure ❑Yes ❑ No

Joint Replacement ❑Yes ❑ No
Type:_____
Date:_____
Doctor:_____
Kidney Disease ❑Yes ❑ No
Kidney Dialysis ❑Yes ❑ No
Latex Sensitivity ❑Yes ❑ No
Lupus ❑Yes ❑ No
Low Blood Pressure ❑Yes ❑ No
Malignancies ❑Yes ❑ No
Neck & Back Problems ❑Yes ❑ No
Nervous Problems ❑Yes ❑ No
Organ/Valve Replaced ❑Yes ❑ No
Type:_____
Date:_____
Doctor:_____
Pacemaker ❑Yes ❑ No
Psychiatric Care ❑Yes ❑ No
Radiation Treatments ❑Yes ❑ No
Respiratory Problems ❑Yes ❑ No
Rheumatic Fever ❑Yes ❑ No
Scarlet Fever ❑Yes ❑ No
Sinus Problems ❑Yes ❑ No

Stroke ❑Yes ❑ No
Thyroid Disease ❑Yes ❑ No
Tuberculosis ❑Yes ❑ No
Ulcers ❑Yes ❑ No
Venereal Disease ❑Yes ❑ No

Are you in general good health? ❑Yes ❑ No

Are you a smoker? ❑Yes ❑ No

Are there any problems not listed you would like to discuss? ❑Yes ❑ No

_____

Primary Care Physician's Name

_____

City_____

Allergies: ❑ None ❑ Penicillin ❑ Latex ❑ Metals ❑ Aspirin ❑ Sulfa ❑ Other _____

Medications: Any currently being taken? ❑No ❑ Yes: Please list all medications or attach list: _____

_____

Injury to Head: ❑ None ❑ Teeth ❑ Face ❑ Mouth ❑ Neck ❑ Other _____

(Women) Is there a possibility of pregnancy? ❑ Yes ❑ No, If Yes, how far along? _____ Due Date:_____

(Child Patient) Has reached puberty? ❑ Yes ❑ No (e.g. girls: Started menstruation, boys: Voice changed/facial hair)

6. Orthodontic and Dental History

What is the reason for this visit?_____

How long since your last dental visit? _____ What was done at that time?_____

Were x-rays taken? ❑ Yes ❑ No, General Dentist _____ City_____Phone_____

Are your teeth sensitive to: ❑Hot? ❑ Cold? ❑Sweets? ❑ Pressure? ❑ No teeth sensitivity

Bleeding of Gums ❑Yes ❑ No, If Yes, when? _____

Clench or grind your teeth? ❑Yes ❑ No

Jaw Pain, does Jaw click or pop? ❑Yes ❑ No

Mouth Breather ❑Yes ❑ No

Speech Difficulties ❑Yes ❑ No

Speech Therapy ❑Yes ❑ No

Prior Orthodontic Consultation ❑Yes ❑ No

Prior Orthodontic Treatment ❑Yes ❑ No
If Yes, at what age? _____

History of sucking thumb or finger? ❑Yes ❑ No
If Yes, until what age? _____

Frequent ear infections, sore throat ❑Yes ❑ No

Have Adenoids/Tonsils been removed? ❑Yes ❑ No
If Yes, at what age? _____

Have you ever had any problems or complications with previous dental treatment? ❑ No ❑ Yes: If yes, please explain:

_____

Are you unhappy with the appearance of your teeth? ❑Yes ❑ No , If yes, what would you change?

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my or my dependent's medical status**. I authorize the staff to perform the necessary dental services that the patient may need and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company or for legal documentation.**

Signature_____Date_____ Relationship:□Self □ Parent □Guardian

Reviewed By:_____ Date_____