Mario J. Parisi, DDS
♦ Orthodontic Specialist ♦
1001 E. Chicago Avenue, Suite 127
Naperville, Illinois 60540
(630) 961-9692

Date _____

1 ADOLESCENT INFORMATION

Accompanied By _____

Name: _____ _____ Height _____ Weight _____
First Mi Last Called Name

Address: _____ Birthday _____

City: _____ State: _____ Zip: _____ Age _____ Sex _____

2 ADULT INFORMATION

FATHER or SELF or GUARDIAN INFORMATION

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

Email: _____ S.S. # _____

How Long at This Address _____ How Long at Previous Address _____

Previous Address if Less Than 3 Years: _____

EMPLOYER/INSURANCE INFORMATION

Employer Name: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Number of Years Employed _____ Occupation _____

Insurance Company Name: _____

Orthodontic Coverage ? Yes___ No___

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone: _____ Group # _____

MOTHER or SPOUSE INFORMATION

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

Email: _____ S.S. # _____

How Long at This Address _____ How Long at Previous Address _____

Previous Address if Less Than 3 Years: _____

EMPLOYER/INSURANCE INFORMATION

Employer Name: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Number of Year Employed _____ Occupation _____

Insurance Company Name: _____

Orthodontic Coverage ? Yes___ No___

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone: _____ Group # _____

3 OTHER INFORMATION

If We Cannot Reach You or in Case of Emergency: Person to Contact: _____ Phone: _____

Names of Other Immediate FamilyMembers Treated by Our Office: _____

Marital Status of Patient: S M D W of Parents (if minor) S M D W Patient Living With: Mother Father Spouse Self Other

Who is the Responsible Party: _____ Who may we Thank for Referring You? _____

Dentist Name: _____ Sports or Hobbies: _____

Address: _____ Phone #: _____ School Name: _____ Grade: _____

Physician Name: _____ Number of Brothers: _____ Ages: _____

Address: _____ Phone #: _____ Number of Sisters: _____ Ages: _____

4 MEDICAL INFORMATION

	YES	NO
Frequent or Severe Headaches:		
Any Heart Disease:		
Any Sinus or Respiratory Disease:		
Any Blood Disease:		
Any Liver Disease:		
Any Thyroid Disease:		
Any Kidney Disease:		
H.I.V. Positive:		
Any Venereal Disease:		
Any Intestinal Disease:		
Any Bone Disease:		
Any Nervous /Emotional Problems:		
Any High or Low Blood Pressure:		
Any Endocrine Problems:		
Any Problems with Wounds Healing:		
Any Tumors or Cancer:		
Tonsilitis/Frequent Sore Throats:		
Any Joint Problems:		
Frequent Colds:		
Snores While Sleeping:		

	YES	NO
Rheumatic/Yellow/Scarlet Fever:		
Acquired Immune Deficiency Syndrome:		
Is Patient Under Medical Care:		
Rheumatism or Arthritis:		
Is the Patient taking any Medications:		
A History of Fainting or Dizziness:		
Does the Patient have a Drug Addiction:		
Is the Patient Pregnant at this Time:		
Measles/Mumps/Chicken Pox:		
Does the Patient Smoke:		
Has the Patient ever had Fever Blisters:		
Is Height & Weight Normal for Age:		
Is the Patient in Good Health:		
Has the Patient had a Physical this Year:		
Has the Patient Reached Puberty:		
If Male, Begun to Shave:		
If Female, Begun to Menstruate:		

Father's Height _____

Mother's Height _____

	YES	NO
Heart Murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		

	YES	NO
Asthma or Hay Fever:		
Tuberculosis:		
Any Broken Bones:		
Prolonged Bleeding:		
Yellow Jaundice:		
Radiation Therapy:		
Chemical Therapy:		
Blood Transfusions:		
Latex Allergy:		
Is the Patient Allergic to Anything:		

What: _____

Are you aware of any other disease, condition, or problem not listed above that we should know about:

If Yes, What: _____

Any Unusual Reactions to Any of the Following:

Asprin: _____ Sulfa Drugs: _____

Barbiturates: _____ Other Medications: _____

Penicillin: _____

List Any Medications Currently Taking: _____

Please Explain: _____

5 DENTAL HISTORY

	Yes	No
Does the Patient Require Premedication Prior to Dental Treatment:		
Has the Patient Seen a General Dentist in the Last Year:		
Any Pain, Clicking or Discomfort In or Near the Ears:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Have You Been Informed of Missing or Extra Permanent Teeth:		
Are You Aware of Any "Gum" Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		
Do You Feel the Patient can Benefit From Orthodontic Treatment:		
Is the Patient Happy with Their "SMILE":		
Does the Patient Want to Improve Their "SMILE" and "BITE":		
Any Past Orthodontic Treatment:		
Any Unfavorable Reaction to Local Anesthetic:		

How Often Do Your Brush _____ Floss _____

Does the Patient Have or Ever Had Any of the Following Habits:

	Yes	No
Cheek, Tongue or Lip Chewing:		
Thumb Sucking:		
Mouth Breathing:		
Finger Nail Biting:		

	Yes	No
Clenching Teeth:		
Tongue Thrusting:		
Grind Teeth:		
Speech Problems:		
Has the Patient Been Examined by an Orthodontist Before:		
If Yes, When: _____		
Have Other Members of the Family had Orthodontic Treatment:		
If Yes , Were You Happy With the Results:		

If No, Why: _____

Patient's Attitude Toward Braces:

Eagerness: _____

Complacency: _____

Willingness: _____

Antagonism: _____

Who First Noticed the Orthodontic Problem:

Parent: _____

Patient: _____

Dentist: _____

Other: _____

Why did Patient Seek this Consultation: _____

What is the Primary Problem: _____

What is Expected from Orthodontic Treatment: _____

Additonal Comments you Wish to Make: _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, maintaining oral hygiene, and keeping appointments, are there any restrictions, handicaps, or problems that might be encountered during treatment: _____

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

Patient Signature **Date** **Parent Signature**

6 MEDICAL HISTORY UPDATE

Date:	Comments:	Signature: