ROBERT J. GOLDMAN, D.D.S.,
ELLIOT S. TAYNOR, D.D.S., P.C.
PATRICK J. SABO, D.M.D.
MARK A. RIENECKER, D.D.S.

PRACTICE LIMITED TO ORTHODONTICS FOR ADULTS AND CHILDREN

Patient's Name (print) _____
(FIRST) (MIDDLE INITIAL) (LAST)

Address_____Zip Code_____ Email Address _____

Male . . Female . . Telephone: Home _____ Business_____ Cell_____

Referred By _____

Birth Date_____ Birthplace _____ Married (Single Divorced Separated Widowed (
(MONTH) (DATE) (YEAR) (CITY) (STATE)

Dentist's Name _____of_____ Date of Last Dental Checkup_____
(CITY)

Physician's Name _____ Date of Last Medical Checkup _____

Your Occupation _____ Your Social Security Number _____

Employer & Address _____

Spouse's Name_____ Spouse's Occupation _____

Spouse's Employer & Address_____ Spouse's Birth Date
_____

Spouse's Social Security Number_____ Spouse's Telephone (Bus)_____ (Cell)_____

Children's Names and Ages
_____

Are any family members currently in treatment? _____ **If so, who?** _____
Currently wearing braces? _____
Wearing Retainers? _____ **Has an appliance** _____ **Invisalign** _____
Waiting to begin treatment? _____

1. WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

_____

2. Are you in good health? _____ 3. Do you have regular medical examinations? _____

4. Has you ever had any of the following (please check)

Anemia _____	Hepatitis_____	Liver or kidney disease _____	***Allergies to any drugs***_____
Diabetes _____	Hives_____	Jaw pain _____	Mitral valve prolapse _____
Asthma _____	Jaundice_____	Rheumatic fever _____	Handicaps or disabilities _____
Epilepsy _____	Pneumonia _____	Blood disorders _____	HIV / AIDS _____
Hay fever _____	Heart disease _____	Chronic headaches _____	Cancer _____
Hemophilia _____	Migraines _____	Fainting_____	

5. Do you require pre-medication for any condition? _____

6. Is there anything else we should know about your general health? _____

7. Do you have any allergies to medications, food, latex, etc? _____

8. Please indicate any medications you are currently taking. _____

9. Have there been any injuries to the face, mouth, teeth, or chin? If yes, please explain_____

10. Are you a mouth-breather? If yes, please explain _____

11. Is there a hereditary background that might contribute to your dental problem
_____

12. Have you ever had any pain / tenderness in your jaw joint (TMJ)? _____

13. Other Remarks _____

_____
(Your signature) (Today's date)