PATRICK J. SABO, D.M.D.

MARK A. RIENECKER, D.D.S., P.C.

PRACTICE LIMITED TO ORTHODONTICS FOR ADULTS AND CHILDREN

Patient's Name (print)_____

Address_____Town_____Zip Code_____

Male ◯ Female ◯ Telephone: Home _____Email Address _____

Whom may we thank for referring you to our office_____

Birth Date (mm/dd/yyyy) _____School_____Grade_____

Dentist's Name_____of (city)_____Date of Last Dental Checkup_____

Physician's Name_____of (city)_____Date of Last Medical Checkup_____

Father's Name_____ Mother's Name_____

Father's Date of Birth_____ Mother's Date of Birth_____

Father's Social Security # _____ Mother's Social Security #_____

Father's Employer & Address_____Mother's Employer & Address_____

Father's Business Phone_____Cell_____Mother's Business Phone_____Cell_____

Parent's Marital Status: Married ◯ Divorced ◯ Widowed ◯ Separated ◯ Single ◯

Other Children's Names and Ages_____

Are any family members currently in treatment? _____ If so, who?_____

Currently wearing braces? _____

Wearing retainers? _____ Has an appliance? _____Invisalign? _____

1.WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH FOR YOUR CHILD?_____

2. Is your child in good health? Yes ◯ No ◯ 3. Does your child have regular medical examinations? Yes ◯ No ◯

4. Has your child ever had any of the following (please check): Anemia ☐ Diabetes ☐ Asthma ☐ Epilepsy ☐ Hay Fever ☐ Hemophilia ☐ Hepatitis ☐ ( ) Hives ☐ Jaundice ☐ Pneumonia ☐ Heart Disease ☐ Migraines ☐ Liver or Kidney Disease ☐ Jaw pain or tenderness/TMJ ☐ Mouth Breather ☐ Thumb Sucker ☐ Nail Biter ☐ Face/Mouth/Tooth Injuries ☐ Rheumatic Fever ☐ Blood Disorders ☐ Chronic Headaches ☐ Fainting/Dizziness ☐ ALLERGIES TO ANY DRUGS ☐ Mitral Valve Prolapse ☐ Handicaps/Disabilities ☐ HIV/AIDS ☐ ADD/ADHD ☐ Cancer ☐ Hereditary background of dental problems? (i.e. underbite, overbite, jaw issues) ☐

5. Does your child require pre-medication for any condition? _____If so, for what?_____

6. Is there anything else we should know about your child's general health (i.e. allergies to foods, medications, LATEX etc.)_____

7. Do you have Dental Insurance? Yes ◯ No ◯ If yes, please indicate name of provider_____

Signature:_____ Today's Date:_____