RIM ORTHODONTICS
PAUL RIM, DMD, MS

CONFIDENTIAL

PATIENT

Date: _________

Patient's Last name: ____________________________First name: ______________________ Middle initial______

I prefer to be called: __________________________ Birth date: ______________ Sex: □Male □Female

Home address _________________________________ City, State, Zip code _________________________________

Home phone (____) _____ -__________ Cell phone (_____) _____ -_________

E-mail address (es) ____

PARENT/GUARDIAN

Custodial parent(s) name (s) ____

Patient lives with (*check all that apply*) □mother □father □stepmother □stepfather □grandparent(s) □ other

*Father's full name _________________________________Title: □Mr □Dr □Other

Occupation: ______________________________________ Email address: ________________________________

Address (*if different*) ____

Home Phone (*if different*): (___) _____ -________Cell phone (____) _____-______ Work phone (___) ___- ____

*Mother's full name ________________________________ Title: □ Mrs □ Ms □Dr □Other

Occupation: ______________________________________ Email address: _______________________________

Address (*if different*) ____

Home Phone (*if different*): (____)____ -_______ Cell phone (____)____ -_______ Work phone (___)____ -_____

DENTIST

Patient's Dentist: ____________________________ City, State: _____________________________________

Other dental specialists being seen: Name__________________________ City, State ___________________

Reason: ____

PHYSICIAN

Patient's Physician: ____

Phone number _______________________________ City, State: ____________________________________

Last examination visit: ____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? ____

Address (*if different from page 1*) City, State, Zip ____

Home phone (___)___ -____ Cell phone (___)____ -______ E-mail address(es) __________________________

Social Security # ___ _-_____ -____ Employer: ____

Financial Responsibility Signature ____Date _______________

DENTAL INSURANCE

Primary policy holder's full name ___________________________ Birth date __________________________

Social Security # _______-____-________ Relationship to patient ___________________________________

Address and phone (if not listed above) ____

Employer ____

Insurance company Name ________________________________ S.S.N/ID#______________________________

Secondary policy holder's full name __________________________ Birth date ____________________________

Social Security # _______-____-________ Relationship to patient ___________________________________

Address and phone (if not listed above) ____

Employer ____

Insurance company Name ________________________________ S.S.N./ID #_______________________________

Your answers are for office records only, and are confidential. A thorough medial history is essential to a complete orthodontic evaluation. ***For the following questions mark yes, no.***

MEDICAL HISTORY

Now or in the past, has your child had:

☐yes ☐no Bone fractures, or major injuries?
☐yes ☐no Any injuries to face, head, and neck?
☐yes ☐no Cancer, tumor, radiation or chemotherapy?
☐yes ☐no Arthritis or joint problems?
☐yes ☐no Endocrine or thyroid problems?
☐yes ☐no Diabetes or low sugar?
☐yes ☐no Kidney problems?
☐yes ☐no Gonorrhea, syphilis, herpes, or STDs?
☐yes ☐no Immune system problems?
☐yes ☐no AIDS or HIV positive?
☐yes ☐no Hepatitis, jaundice or other liver problem?
☐yes ☐no Polio,mononucleosis,tuberculosis,pneumonia?
☐yes ☐no Seizures, fainting spells, neurologic problem?
☐yes ☐no Mental health disturbance or depression?
☐yes ☐no History of eating disorders?
☐yes ☐no Frequent headaches or migraines?

☐yes ☐no Excessive bleeding/bruising tendency, anemia?
☐yes ☐no Birth defects/hereditary problems?
☐yes ☐no Chest pain, shortness of breath, tire easily, swollen ankles?
☐yes ☐no Heart defects, heart murmur, rheumatic heart disease?
☐yes ☐no Angina, arteriosclerosis, stroke or heart attack?
☐yes ☐no Skin disorder (other than common acne)?
☐yes ☐no Does your child eat a well-balanced diet?
☐yes ☐no Vision, hearing, or speech problems?
☐yes ☐no Frequent ear infections, colds, throat infections?
☐yes ☐no Asthma, sinus problems, hay fever?
☐yes ☐no Tonsil or adenoid condition?
☐yes ☐no Does your child frequently breathe through mouth?
☐yes ☐no High or low blood pressure?

DENTAL HISTORY

Now or in the past, has your child had:

- ☐yes ☐no Erupting teeth very early or very late?
- ☐yes ☐no Primary teeth removed that were not loose?
- ☐yes ☐no Permanent or extra teeth removed?
- ☐yes ☐no Extra or congenitally missing teeth?
- ☐yes ☐no Injured primary or permanent teeth?
- ☐yes ☐no Any sensitive or sore teeth?
- ☐yes ☐no Any lost or broken fillings?
- ☐yes ☐no Jaw fractures, cysts, infections?
- ☐yes ☐no Teeth treated with root canals?
- ☐yes ☐no Frequent canker sores/ cold sores?
- ☐yes ☐no Difficulty breathing through nose?
- ☐yes ☐no Food impaction between the teeth?
- ☐yes ☐no History of speech problems?
- ☐yes ☐no Oral habits (sucking finger, chewing pen, etc.)?
- ☐yes ☐no Teeth causing irritation to lip, cheek or gums?
- ☐yes ☐no Abnormal swallowing (tongue thrust)?
- ☐yes ☐no Tooth grinding or clenching?
- ☐yes ☐no Clicking, locking in jaw joints?
- ☐yes ☐no Soreness in jaw muscles or face muscles?
- ☐yes ☐no Ringing in ears, difficulty in chewing or opening jaw?
- ☐yes ☐no Has your child been treated for TMJ/TMD problems?
- ☐yes ☐no Any trouble associated with previous dental treatment?
- ☐yes ☐no Has he/she been diagnosed with gum disease/pyorrhea?
- ☐yes ☐no Mouth breathing habit or snoring at night?

HAS YOUR CHILD HAD ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING:

- **☐yes ☐no Local anesthetics**
- **☐yes ☐no Latex (gloves, balloons)**
- **☐yes ☐no Aspirin**
- **☐yes ☐no Ibuprofen (Motrin, Advil)**
- **☐yes ☐no Penicillin**
- **☐yes ☐no Other antibiotics**
- **☐yes ☐no Metals (jewelry, clothing snaps)**
- **☐yes ☐no Acrylics**
- **☐yes ☐no Plant pollens**
- **☐yes ☐no Animals**
- **☐yes ☐no Foods**
- **☐yes ☐no Other substances**

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? How?

____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication Taken for ____

Does the patient currently have (or ever had) a substance abuse problem? ____________________

Does your child chew or smoke tobacco? ____________________________________

Have you noticed any unusual changes in your child's face or jaws? ____________________

Any other physical problems? ____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please explain.

____

Bleeding disorders	☐yes	☐no	Diabetes	☐yes	☐no
Arthritis	☐yes	☐no	Severe allergies	☐yes	☐no
Unusual dental problems	☐yes	☐no	Jaw size imbalance	☐yes	☐no
Other family medical conditions?	☐yes	☐no			

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company. I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my child's medical or dental health.

Hipaa acknowledgement: Copy of the rules and regulations regarding the protected health information is posted in our office.

Parent / Guardian signature____

Date______________________________

MEDICAL HISTORY UPDATES

Changes
Parent/Guardian Signature ____
Date______________________________
Dental Staff Signature ____
Date______________________________

Changes
Parent/Guardian Signature ____
Date______________________________
Dental Staff Signature ____

Office Use Only:

____
____
____
____
____

WELCOME TO OUR OFFICE

We would like to get to know you so that we can provide you with the best orthodontic care possible. To help us please answer the following questions.

I like to be called_________________________________.

In my spare time, I like to____.

The sports I enjoy are______________________________.

My favorite kind of music is
____.

The things I like best about school are
____.

Do you have any pets? __________ What kind and what are their names?___________________.

I think having braces would be
____.

Do you have friends who have braces?
____.

Is there something special about you that you would like us to know?
____.

Thank you for this opportunity to get to know you better!