RIM ORTHODONTICS
PAUL RIM, DMD, MS

PATIENT

Date: _____

Patient's Last name: _____

First name: _____ Middle initial_____ Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Dr. ☐Other

I prefer to be called: _____

Birth date: _____ Sex: ☐Male ☐Female Social Security # _____-_____ -_____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Home address _____ City, State, Zip code _____

Home phone (____) _____ -_____ Cell phone (_____) _____ -_____ Work phone (_____) _____-_____

E-mail address (es) _____

Occupation Employer: _____

CLOSEST RELATIVE

Spouse or closest relatives name(s)

_____

Title ☐Mr. ☐Mrs. ☐ Ms. ☐Miss. ☐Dr. ☐Other Relationship to patient _____

Address *(if different than patient address)* _____

Home phone ( ) _____-_____ 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 (if different from above)?

_____

Address (*if different from above*) 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 _____ Birthdate _____

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 _____ Birthdate _____

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, or don't know/understand (dk/u).***

MEDICAL HISTORY

Now or in the past, have you had (please circle):

□yes □no	Birth defects or hereditary problems?	□yes □no	Vision, hearing, or speech problems?
□yes □no	Bone fractures, or major injuries?	□yes □no	History of eating disorder (anorexia, bulimia)?
□yes □no	Any injuries to face, head, neck?	□yes □no	High or low blood pressure?
□yes □no	Arthritis or joint problems?	□yes □no	Excessive bleeding or bruising, anemia?
□yes □no	Endocrine or thyroid problems?	□yes □no	Chest pain, short of breath, fatigue, swollen ankles?
□yes □no	Diabetes or low sugar?	□yes □no	Heart defects, heart murmur, rheumatic heart disease?
□yes □no	Kidney problems?	□yes □no	Angina, arteriosclerosis, stroke or heart attack?
□yes □no	Stomach ulcer, hyperacidity, acid reflux?	□yes □no	Cancer, tumor, radiation or Chemotherapy?
□yes □no	Immune system problems?	□yes □no	Skin disorder (other than acne)?
□yes □no	History of osteoporosis?	□yes □no	Do you eat a well-balanced diet?
□yes □no	Gonorrhea, syphilis, herpes, or STDs?	□yes □no	Frequent headaches or migraines?
□yes □no	AIDS or HIV positive?	□yes □no	Frequent ear infections, colds, throat infections?
□yes □no	Polio,mononucleosis,tuberculosis,pneumonia?	□yes □no	Asthma, sinus problems, hayfever?
□yes □no	Hepatitis, jaundice or other liver problem?	□yes □no	Tonsil or adenoid condition?
		□yes □no	Do you frequently breathe through your mouth?

DENTAL HISTORY

Now or in the past, have you had:

□yes □no	Permanent or extra teeth removed?	□yes □no	Oral habits (sucking finger, chewing pen, etc.)?
□yes □no	Extra or congenitally missing teeth?	□yes □no	Teeth causing irritation to lip, cheek or gums?
□yes □no	Chipped or injured primary or permanent teeth?	□yes □no	Abnormal swallowing (tongue thrust)?
		□yes □no	Tooth grinding or clenching?
□yes □no	Any sensitive or sore teeth?	□yes □no	Clicking, locking in jaw joints?
□yes □no	Bleeding gums, bad taste or mouth odor?	□yes □no	Soreness in jaw muscles or face muscles?
□yes □no	Jaw fractures, cysts, infections?	□yes □no	Ringing in ears, difficulty in chewing or opening jaw?
□yes □no	Teeth treated with root canals pulpotomies?	□yes □no	Have you ever been treated for "TMJ" or "TMD"?
□yes □no	Gum boils, frequent canker sores/ coldsores?	□yes □no	Any broken or missing fillings?
□yes □no	History of speech problems/speech therapy?	□yes □no	Any trouble associate with previous dental treatment?
□yes □no	Difficulty breathing through nose?	□yes □no	Have you been diagnosed with gum disease/pyorrhea?
□yes □no	Food impaction between the teeth?		
□yes □no	Mouth breathing habit or snoring at night?	□yes □no	Have you ever had an orthodontic consultation or treatment before now?

HAVE YOU HAD ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING:

□yes □no □dk/u	Local anesthetics (novocaine, lido, xylocaine)	□yes □no	Metals (jewelry, clothing snaps)
□yes □no □dk/u	Latex (gloves, balloons)	□yes □no	Acrylics
□yes □no □dk/u	Aspirin	□yes □no	Plant pollens
□yes □no □dk/u	Ibuprofen (Motrin, Advil)	□yes □no	Animals
□yes □no □dk/u	Penicillin	□yes □no	Foods
□yes □no □dk/u	Other antibiotics	□yes □no	Other substances

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication Taken for:_____

Have you ever taken any medications to strengthen your bones? Please describe.

Do you chew or smoke tobacco? _____

Have you noticed any changes in your face or jaws? _____

Any other physical problems? _____

How often do you brush? _____

How often do you floss?_____

Women: Are you pregnant? □Yes □No Are you trying to become pregnant? □Yes □No

FAMILY MEDICAL HISTORY

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

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental 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 medical or dental health.

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

Signature _____

Date_____

MEDICAL HISTORY UPDATES OR CHANGES

Changes

Patient Signature _____

Date_____

Dental Staff Signature _____

Date_____

Changes

Patient Signature _____

Date_____

Dental Staff Signature _____

Date_____

Office Use Only:

_____

_____

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