



# Interdisciplinary Dentofacial Diagnostic Systems

## Terry G. Box, DDS

COMPREHENSIVE RESTORATIVE DENTISTRY

Chart Number: \_\_\_\_\_

Date: \_\_\_\_\_

### PATIENT'S INFORMATION (please completely fill out first and second pages)

Patient's Full Name: \_\_\_\_\_ Name you like to be called by: \_\_\_\_\_  
*First, Middle, Last*

Patient's Address: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
*Street, Apt. No., City, State, Zip*

Home Phone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status:  Single  Married  Divorced  Separated  Widowed

Place of Employment or School and Grade: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Contact's Address: \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_ Names and Ages of Children or Siblings: \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

Full Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
*First, Middle, Last*

Full Home Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
*Street, Apt. No., City, State, Zip*

If Less than 3 Years at above, Previous Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed Occupation: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Years at Employer: \_\_\_\_ Employer's Address: \_\_\_\_\_

Name of  Spouse  Other Parent \_\_\_\_\_ Full Address: \_\_\_\_\_  
or  Secondary Responsible Person: *First, Middle, Last*

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation (type of business): \_\_\_\_\_ Years at Employer: \_\_\_\_\_

### INSURANCE INFORMATION

*If you have insurance, this section must be completed*

Dental Insurance Company (name and address): \_\_\_\_\_

Name of Subscriber/Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Group #: \_\_\_\_\_ Identification #: \_\_\_\_\_ Other Number(s) \_\_\_\_\_

Secondary Dental Insurance Company (name and address): \_\_\_\_\_

Name of Subscriber/Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Group #: \_\_\_\_\_ Identification #: \_\_\_\_\_ Other Number(s) \_\_\_\_\_

Medical Insurance Company (name and address): \_\_\_\_\_

Name of Subscriber/Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Group #: \_\_\_\_\_ Identification #: \_\_\_\_\_ Other Number(s) \_\_\_\_\_

Secondary Medical Insurance Company (name and address): \_\_\_\_\_

Name of Subscriber/Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Group #: \_\_\_\_\_ Identification #: \_\_\_\_\_ Other Number(s) \_\_\_\_\_

### RELEASE

I authorize the doctor or other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care.

I authorize release of any information concerning my (or my child's) health care for advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members.

I consent to the release of credit reports and information regarding my credit history to the doctor(s).

I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

Date: \_\_\_\_\_ Patient or Guardian's Signature: \_\_\_\_\_

Updated: \_\_\_\_\_ Patient or Guardian's Signature: \_\_\_\_\_

**MEDICAL AND DENTAL HISTORY** (to be completed by patient)

Patient's Full Name: \_\_\_\_\_  Male  Female  
 Date of Birth: \_\_\_\_\_ Age: (years) \_\_\_\_\_ (months) \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Patient's  Current  Previous Dentist(s): \_\_\_\_\_ Date of Last Dental Cleaning: \_\_\_\_\_  
 Patient's  Current  Previous Physician(s): \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions (use bottom of page if necessary). THANK YOU.

- A Please list your chief concerns for treatment: (# in order of priority): \_\_\_\_\_
- B What or who motivated you to seek treatment and what do you expect? \_\_\_\_\_
- C Describe anything that bothers you about the appearance of your teeth, smile or face: \_\_\_\_\_
- D Describe any injuries or blows to your face, jaw, mouth or teeth: \_\_\_\_\_
- E List all current medications including non-prescriptions: \_\_\_\_\_
- F List all drug allergies: \_\_\_\_\_
- G List all previous surgeries or hospitalizations: \_\_\_\_\_

Please ✓ if "yes" to every question appropriate, and thoroughly describe (use space at bottom of page if necessary)

- |  |  |  |
|--|--|--|
| <b>MEDICAL</b>   |  |  |
| 1 High Blood Pressure _____ <input type="checkbox"/>                                 | 31 Pregnant or possible pregnant _____ <input type="checkbox"/>                        |  |
| 2 Chest pains or heart attack _____ <input type="checkbox"/>                         | 32 Taking birth control pills _____ <input type="checkbox"/>                           |  |
| 3 Stroke _____ <input type="checkbox"/>  | 33 Drink coffee (cups per day) _____ <input type="checkbox"/>                          |  |
| 4 Rheumatic Fever _____ <input type="checkbox"/>                                     | 34 Use tobacco (types/how much) _____ <input type="checkbox"/>                         |  |
| 5 Shortness of breath or swollen ankles _____ <input type="checkbox"/>               | 35 Consume alcoholic beverages _____ <input type="checkbox"/>                          |  |
| 6 Any heart trouble, murmur, or mitral valve prolapse _____ <input type="checkbox"/> | 36 Pain, popping, catching or locking in jaw joints _____ <input type="checkbox"/>     |  |
| 7 Prosthetic devices (heart, valve, hip, etc.) _____ <input type="checkbox"/>        | 37 Clench or grind your teeth _____ <input type="checkbox"/>                           |  |
| 8 Any lung disease (T.B., emphysema, etc.) _____ <input type="checkbox"/>            | 38 Wake up with sore jaws _____ <input type="checkbox"/>                               |  |
| 9 Asthma _____ <input type="checkbox"/>  | 39 Frequent headaches (How many per week? _____) _____ <input type="checkbox"/>        |  |
| 10 Allergies or hay fever _____ <input type="checkbox"/>                             | 40 Dizziness, ringing or pain in ears _____ <input type="checkbox"/>                   |  |
| 11 Sinus problems _____ <input type="checkbox"/>                                     | 41 Tenderness or stiffness in the jaw, neck or back _____ <input type="checkbox"/>     |  |
| 12 Mouthbreathing or excessive snoring _____ <input type="checkbox"/>                | 42 History of TMJ (jaw joint) problems or therapy _____ <input type="checkbox"/>       |  |
| 13 Ulcers or stomach problems _____ <input type="checkbox"/>                         |  |  |
| 14 Diabetes _____ <input type="checkbox"/>   | <b>DENTAL</b>  |  |
| 15 Hepatitis or liver disease _____ <input type="checkbox"/>                         | 50 Treated for or told you have gum disease _____ <input type="checkbox"/>             |  |
| 16 Kidney or bladder disease _____ <input type="checkbox"/>                          | 51 Treated or consulted for orthodontic therapy _____ <input type="checkbox"/>         |  |
| 17 Thyroid trouble _____ <input type="checkbox"/>                                    | 52 Had any oral surgery _____ <input type="checkbox"/>                                 |  |
| 18 Connective tissue disease _____ <input type="checkbox"/>                          | 53 Dental x-rays taken in the last year _____ <input type="checkbox"/>                 |  |
| 19 Sexually transmitted disease _____ <input type="checkbox"/>                       | 54 Excessive fear of dental treatment _____ <input type="checkbox"/>                   |  |
| 20 Arthritis or rheumatism _____ <input type="checkbox"/>                            | 55 Brush your teeth (how often) _____ <input type="checkbox"/>                         |  |
| 21 Cancer (type, date) _____ <input type="checkbox"/>                                | 56 Floss your teeth (how often) _____ <input type="checkbox"/>                         |  |
| 22 Serious illnesses not listed (list-type, date) _____ <input type="checkbox"/>     | 57 Bad breath or unpleasant tastes in your mouth _____ <input type="checkbox"/>        |  |
| 23 Subject to prolonged bleeding or bruise easily _____ <input type="checkbox"/>     | 58 Bleeding gums _____ <input type="checkbox"/>  |  |
| 24 A contact lens user _____ <input type="checkbox"/>                                | 59 Sore teeth _____ <input type="checkbox"/>   |  |
| 25 Glaucoma _____ <input type="checkbox"/>   | 60 Tooth sensitivity (hot, cold, sweets) _____ <input type="checkbox"/>                |  |
| 26 Epilepsy, convulsions or seizures _____ <input type="checkbox"/>                  | 61 Fever blisters or mouth ulcers _____ <input type="checkbox"/>                       |  |
| 27 Psychiatric therapy or emotional problems _____ <input type="checkbox"/>          | 62 Suck your thumb, finger or lip (now or in the past?) _____ <input type="checkbox"/> |  |
| 28 Do you have HIV (AIDS)? _____ <input type="checkbox"/>                            | 63 Tongue thrusting habit _____ <input type="checkbox"/>                               |  |
| 29 Have you been exposed to HIV? _____ <input type="checkbox"/>                      | 64 Gag easily _____ <input type="checkbox"/>   |  |
| 30 Have you been tested for HIV? _____ <input type="checkbox"/>                      | 65 Place a high priority on keeping your natural teeth _____ <input type="checkbox"/>  |  |

Please expand on the above information (refer to letter or number) or add anything you feel is important: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge: ©IDT Systems, Inc.  
 Date: \_\_\_\_\_ Patient or Guardian's Signature: \_\_\_\_\_ Doctor's Signature: \_\_\_\_\_  
 Updated: \_\_\_\_\_ P or G's Initials: \_\_\_\_\_ Doctor's Initials: \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_