Welcome To Our Office

Date:_____

Patient Information

Name:_____ Nickname:_____

Birthdate_____ Sex M____F____

Home Address_____

City_____ State_____ Zip_____

Sports/Hobbies_____

General Dentist_____

Whom may we thank for referring you?_____

Person Financially Responsible_____

Please describe your problems/concerns_____

What do you expect from treatment?_____

Parent/ Guardian Information

Father/Guardian Name_____ DOB_____

Address(if different from patient)_____

Home/ Cell Phone_____ Work Phone_____

SSN_____ Email :_____

Mother/Guardian Name_____

Address(if different from patient)_____

Home/ Cell Phone_____ WorkPhone _____

SSN_____Email_____

Parents Marital Status

Single _____ Married_____ Divorced_____ Widow(er)_____

Insurance Information

Primary

Insurance Company_____

Member ID_____

Group#_____

Insured_____

Employer_____

Secondary

Insurance Company_____

Member ID_____

Group#_____

Insured_____

Employer_____

Dental History

Frequency of Checkups Twice a year_____ Once a year_____ Only if a problem arises _____Other_____

Date of last visit_____ For what service_____

Is there any unfinished care to be completed with your child's dentist? Y____N____

Explain_____

Have teeth (either baby or permanent) been removed? Y____N____

Explain_____

Has your child had any face or dental injuries? Y____N____

Explain_____

Does your child play any musical instrument? Y____N____

What instrument(s)_____

Was an orthodontist consulted previously? Y____N____

Type of treatment_____

Does the patient desire orthodontic treatment? Y____N____

Please check if there is a history of:

- ☐ Clenching teeth
- ☐ Grinding teeth
- ☐ Headaches
- ☐ Ringing in the ears
- ☐ Jaw joint popping, clicking or soreness (explain)_____
- ☐ Speech problems (explain)_____

Is there any other information that may be helpful?_____

Medical History

Child's Physician_____Last Visit_____

Is child in good health? Y____N____ Explain_____

Child taking any drugs/medication? Y____N____ List_____

_____

Allergies to any medication(s)? Y____N____ List_____

Food or Other Allergies? (i.e. Latex) Y____N____ List_____

Rheumatic fever, heart disease, murmur? Y____N____ Explain_____

Tonsils and/or adenoids removed? Y____N____ Explain_____

Any learning/emotional disorders? Y____N____ Explain_____

Serious illness or hospitalization? Y____N____ Explain_____

Other_____

Signature of Parent/Guardian_____Date_____

Joseph LaPonzina, D.D.S., P.A.
Orthodontic Specialist

2103 Laurel Bush Road, Suite D
Bel Air, MD 21015
(410) 515-0035

ADULT PATIENT INFORMATION

Name: Ms. Mrs. Mr. Dr. _____ Prefer to be called: _____ Sex: _____
(First) (Last)

Address: _____ City: _____ Zip: _____

Home Phone: _____ Age: _____ Birthdate: _____ SS#: _____

Occupation: _____ Bus. Address: _____ Bus. Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)

Spouse's Name: Ms. Mrs. Mr. Dr. _____ Occupation: _____ Bus. Phone: _____
(First) (Last)

Who will be responsible for this account? _____

Is their dental insurance? _____ Name of Carrier _____

Whom may we thank for referring you to our office? _____

Please describe your problem and concerns: _____

_____

What do you expect from treatment? _____

DENTAL HISTORY

General Dentist: _____ Address: _____ Phone: _____

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ Only if a problem arises ☐ Never Date of last visit: _____

Is there any unfinished care to be completed with your dentist? ☐ No ☐ Yes Explain: _____

Have you ever had a periodontal (gum) disease? ☐ No ☐ Yes Explain: _____

Have you had any face or dental injuries? ☐ No ☐ Yes Explain: _____

Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes Explain: _____

Have you consulted an orthodontist previously? ☐ No ☐ Yes Explain: _____

Have you noticed any changes in your bite or dental alignment recently? ☐ No ☐ Yes _____

Explain:

Please check if there is a history of:

☐ Clenching teeth	☐ Frequent headaches	☐ Jaw joint soreness	☐ Jaw joint popping
☐ Grinding teeth	☐ Muscle soreness around head & neck	☐ Jaw joint clicking	☐ Ringing in the ears
☐ Speech problems	☐ Difficulty opening mouth wide	☐ Mouthbreathing while:	☐ Awake ☐ Asleep

Is there any other information that may be helpful? _____

Please Turn Over

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing for your dental care. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Last Visit: _____

Address: _____ Phone: _____

Have you experienced any health problems? ☐ No ☐ Yes Explain: _____

Any major change in your health recently? ☐ No ☐ Yes Explain: _____

Are you currently under a physician's care? ☐ No ☐ Yes Explain: _____

Are you currently taking medications? ☐ No ☐ Yes List: _____

Are you allergic to any medications? ☐ No ☐ Yes List: _____

Have you received a blood transfusion? ☐ No ☐ Yes Reason: _____

Have your tonsils or adenoids been removed? ☐ No ☐ Yes When: _____

Have you been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check if you have had any of the following conditions:

Heart Murmur	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Emotional Problems	☐ No	☐ Yes
Heart Surgery	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Frequent Headaches	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes	Nervous/Anxious	☐ No	☐ Yes
Endocrine Disorders	☐ No	☐ Yes	Liver Disease	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Prolonged Bleeding	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Bone Disorders	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes	Growth Disorders	☐ No	☐ Yes
Blood Disease	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Mouth Breather	☐ No	☐ Yes
Developmental Disorder	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Herpes (Fever Blisters)	☐ No	☐ Yes
Hives/Rash	☐ No	☐ Yes	Fainting	☐ No	☐ Yes	Tonsillitis	☐ No	☐ Yes

PRIMARY

PATIENT INSURANCE INFORMATION

PATIENT NAME (if dependent) — RELATION TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

EMPLOYEE NAME

SOCIAL SECURITY NUMBER OF EMPLOYEE — BIRTH DATE

EMPLOYER — UNION NO.

GROUP PLAN NAME — GROUP NO.

PRIMARY CARRIER NAME — POLICY NO.

SECONDARY CARRIER NAME — POLICY NO.

SECONDARY

PATIENT INSURANCE INFORMATION

PATIENT NAME (if dependent) — RELATION TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

EMPLOYEE NAME

SOCIAL SECURITY NUMBER OF EMPLOYEE — BIRTH DATE

EMPLOYER — UNION NO.

GROUP PLAN NAME — GROUP NO.

PRIMARY CARRIER NAME — POLICY NO.

SECONDARY CARRIER NAME — POLICY NO.

INSURANCE: To avoid misunderstandings regarding dental insurance, all professional services are charged directly to the patient and the patient is responsible for payment of fees. We will prepare necessary forms or reports to help you obtain benefits from your insurance company.

Patient's Signature _____ Date _____