CARUSO ORTHODONTICS

Children & Adults

Paul M. Caruso
DDS

Member
American Association of
Orthodontists

Today's Date _____ General Dentist _____
Patient Name _____ Date of Birth ___/___/___ Age_____
Address _____ City _____
State _____ Zip _____ SS# _____/_____/_____
Phone _____ Cell _____
Email Address _____
Immediate Family members treated by Dr. Caruso _____
Whom may we thank for referring you _____

ADULTS PLEASE CONTINUE AT THE RESPONSIBLE PARTY SELECTION *

Father's Information
Name_____ Date Of Birth_____
Address_____ Phone_____ SS#___/___/____
City_____ State_____ Zip Code_____
Employer_____ Phone_____
Business Address_____ Zip Code_____

Mother's Information
Name _____ Date of Birth_____
Address_____ Phone_____ SS#___/___/____
City _____ State_____ Zip Code_____
Employer_____ Phone_____
Business Address_____ Zip Code_____

*** RESPONSIBLE PARTY**

Name_____ Date of Birth_____
Address_____ Phone_____ SS#___/___/____
City_____ State_____ Zip Code_____
Employer_____ Phone_____
Business Address_____ Zip Code_____

IF YOU HAVE INSURANCE COVERAGE, PLEASE PROVIDE US WITH A COMPLETED FORM

What are the main concerns that you would like orthodontics to accomplish?

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Y N Has The Patient Ever Been Evaluated Or Had Orthodontic Treatment?
Y N Have There Been Any Injuries To The Face, Mouth, Teeth, Or Chin?
Y N Have Adenoids Or Tonsils Been Removed?
Y N Has The Patient Been Informed Of Any Missing Or Extra Permanent Teeth?
Y N Have You Or Your Child Ever Had Any Pain/Tenderness In The Jaw Joint? If Yes, You _____ Child _____
Y N Is The Patient Under The Care Of A Physician Currently?

Physician_____ Phone_____

338 East State Street Herkimer New York 13350 Telephone 315-866-2344
10 Dietz Street Oneonta New York 13820 Telephone 607-431-1021
1 Paris Road New Hartford New York 13413 Telephone 315-724-5800

Please List All Drugs That The Patient Is Currently Taking

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Please Discuss Any Medical Problems

Does/Did The Patient Have Any Of The Following Habits?

Y	N	Clenching/ Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking/ Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb/ Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Has The Patient Ever Had Any Of The Following?

Y	N	Abnormal Bleeding	Y	N	Heart Surgery/Pacemaker
Y	N	Allergy To Latex/Metals	Y	N	Heart/Murmur
Y	N	Anemia/Radiation Treatment	Y	N	Hemophilia
Y	N	Artificial Bones/Joints	Y	N	Hepatitis
Y	N	Artificial Valves	Y	N	High/Low Blood Pressure
Y	N	Asthma	Y	N	HIV /AIDS
Y	N	Blood Transfusion	Y	N	Kidney/Liver Problems
Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Convulsions/Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Diabetes/Tuberculosis	Y	N	Severe/Frequent Headaches
Y	N	Difficulty Breathing	Y	N	Shingles/Chicken Pox
Y	N	Drug/Alcohol Abuse	Y	N	Sinus Problems
Y	N	Emphysema/Glaucoma	Y	N	Hearing Impaired
Y	N	Fever Blisters/Herpes	Y	N	Ulcers/Colitis
Y	N	Handicaps/Disabilities	Y	N	Onset Of Puberty
Y	N	Heart Attack/Stroke	Y	N	Allergies To Any Drugs(List)

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Y N Hospitalized For Any Reason?_____

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Y N **Is It Necessary To Premedicate Before Dental Procedures?**

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services needed.

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Signature of Parent Or Guardian Or Self Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

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Signature of Parent Or Guardian Or Self Date