JOHN J. CONROY D.M.D., M.S., P.C.
DOUG H. MACGILPIN D.D.S., M.S.
Orthodontics and Dentofacial Orthopedics
For Children and Adults

www.conroyortho.com

465 Silas Deane Highway
Wethersfield, CT 06109
860-529-7200

141 Coe Ave.
Middletown, CT 06457
860-347-4618

CONFIDENTIAL – PATIENT HISTORY FORM - PATIENTS UNDER 18 YRS

_____
Today's Date

_____ _____ _____ _____
Patient Last Name **First Name** Middle Birth Date

__M / F___ _____ _____
SEX **Nick name** What school do you go to?

_____ _____
Address (Street, City, State, Zip Code) How long at this address? Home Phone Number

_____ _____
Home Email Address Patient's Cell Phone Number/Carrier

_____ _____ _____ _____
Name of Father Employed By/How long? Work Phone Number Father Cell Phone Number/Carrier

Address (if different) from patient_____ Home #_____

_____ _____ _____ _____
Name of Mother Employed By/How long? Work Phone Number Mother Cell Phone Number/Carrier

Address(if different) from patient_____ Home #_____

Are Parents: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Siblings and Ages _____

Whom can we thank for sending you to our practice? _____

Favorite Sports,Hobbies_____

Dentist Name and City_____Date of Last Dental Cleaning _____How often do you visit Dentist?_____

Physician Name and City _____

Orthodontic Insurance Coverage: _____ Yes _____ No If yes, please complete below:

ORTHODONTIC PRIMARY CARRIER	**SECONDARY CARRIER**
Name of Subscriber_____	_____
Subscriber's ID #_____Group # _____	_____
Subscriber's DOB_____	_____
Subscriber's Employer _____	_____
Insurance Co._____	_____
Insurance Co. Address_____	_____
Insurance Co. Phone #_____	_____

Please answer Medical and Dental History questions on page 2

For the following questions, circle YES or NO whichever applies. Your answers are for office records only and will be considered confidential.

MEDICAL HISTORY

Is the patient in good health?	YES	NO
Any changes in general health within the past year?	YES	NO
Any hospitalizations or serious illness within the past 5 years?	YES	NO

Does the patient have (or had) any of the following diseases or problems?

Heart Murmur	YES	NO	Rheumatic fever or rheumatic heart diseases	YES	NO
If yes do you take antibiotics for dental procedures? _____			High or low blood pressure	YES	NO
Congenital heart lesions	YES	NO	Rheumatoid or arthritis conditions	YES	NO
Birth defects or hereditary problems	YES	NO	Hepatitis or liver problems	YES	NO
Thyroid Problems	YES	NO	Sexually transmitted disease	YES	NO
Diabetes	YES	NO	Vision or hearing problems	YES	NO
AIDS or HIV positive	YES	NO	Fainting spells, seizures, or epilepsy	YES	NO
Mental Health or Behavioral Problems	YES	NO	Bleeding or bruising problems	YES	NO
Tuberculosis	YES	NO	Immune System Disorder	YES	NO
Allergies	YES	NO	Tonsil or adenoid problems	YES	NO
Bone Fractures	YES	NO	Mouth breathing or snoring	YES	NO
Latex Allergy	YES	NO	Asthma	YES	NO
Osteoporosis	YES	NO	Are you a Smoker?	YES	NO

Please list any medications currently taking.

_____

_____

_____

Female Patients

Are you pregnant? YES NO

DENTAL HISTORY

"TMJ" problems (jaw joint/facial muscle pain)	YES	NO	Extractions of primary/permanent teeth	YES	NO
Difficulties opening/closing jaw	YES	NO	Orthodontic treatment in the past	YES	NO
Teeth grinding or clenching	YES	NO	Wisdom teeth problems	YES	NO
Thumb, finger, or sucking habit	YES	NO	History of congenitally missing teeth	YES	NO
Sensitive teeth	YES	NO	Parental history of orthodontics:		
History of dental trauma or chipped teeth	YES	NO	* Mother	YES	NO
Periodontal "gum problems"	YES	NO	with extractions	YES	NO
Missing or removed teeth	YES	NO	* Father	YES	NO
Food impaction between teeth	YES	NO	with extractions	YES	NO
History of supernumerary (extra) teeth	YES	NO			

What is your primary concern – why are you here? _____

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Conroy to perform a complete orthodontic evaluation.

_____ _____

Signature of Patient/Parent/Guardian Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Privacy Practices.

Patient or Responsible Party Signature_____ Date_____/_____/_____