

Tanzilli Orthodontics



Goshen Professional Center
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We are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following forms as completely as you can. If you have any questions, just ask- we will be glad to help. We look forward to working with you!

PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Social Security # _____ Nickname _____

Home Phone _____ Work/Cell Phone _____

Sex: M _____ F _____ Age: _____ Birth Date _____

Occupation: _____ Employed by: _____

Hobbies? _____

Name of General Dentist: _____

What 2 months of the year, do the hygiene cleanings occur? _____

Whom may we thank for referring you? _____

Whom may we notify in case of emergency? _____ Phone # _____

Person Financially responsible: _____ Relationship: _____

Address (if different from above) _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ Work/Cell Phone _____

Parent's Email Address: _____

INSURANCE

Subscriber's Name: _____

Relationship to patient _____ Birth Date of Insured _____

Social Security # of Insured: _____ Phone # _____

Occupation: _____ Employed by: _____

Insurance company: _____ Telephone # _____

Insurance Claim Address: _____

Group _____ Other: _____



Medical Health History

Patient Name: _____

Date: _____

1. Name and address of physician: _____
2. Are you (your child) now under the care of a physician? **YES NO** If so, what is the condition being treated?

3. Have you (your child) been hospitalized in the past 2 years? **YES NO** If so, for what? _____
4. Please list all medications (includes over the counter drugs) you (your child) currently take: _____
5. Please list **ANY ALLERGIES** you (your child) have had (include medicines): _____
6. Have you ever taken the appetite-suppressant FENFLURAMINE AND DEXFENFLURAMINE (FEN-PHEN)? **YES NO**

7. WOMEN: Are you Pregnant? **YES NO**

PLEASE CHECK (✓) IF YOU (YOUR CHILD) HAVE OR HAVE HAD ANY OF THE FOLLOWING:

- | | | |
|--------------------------------------------------|------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Damaged Heart Valve | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Abnormal or Prolonged Bleeding |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting Spells or Seizures | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Trauma to Face |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sinus Problem |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> TMJ Symptoms |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Jaw Noises or Clicks | <input type="checkbox"/> Steroid Treatment |
| <input type="checkbox"/> LATEX ALLERGY | <input type="checkbox"/> NICKEL/METAL ALLERGY | |

Do you have **ANY** disease, condition, or problem not listed that I should know about? **YES NO**
If so, please explain _____

I have reviewed the questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by Dr. Tanzilli, to determine appropriate orthodontic treatment, and I agree to notify Dr. Tanzilli, if any changes in my (my child's) health status should occur.

Signature: _____ **Date:** _____

**If you are signing on behalf of a minor, please state your relationship to the child: _____