RIVIERA ORTHODONTICS

ARASH BAKHTARI, DDS, MS

Patient's Clinical History/Family Information *(please complete in ink)*

Name _____
LAST FIRST M.I.

Date of Birth_____/_____/_____ Age_____ Sex_____ SSN: ____ - ___ - ____
MM DD YY

Address _____
Number Street Suite/Apt. City ZIP

Tel. (____)_____ Cell Phone (____) _____

Employed by _____ Occupation_____

Employer Address _____

Email Address: _____

Best Telephone Number To Contact You During Business Hours (___) _____

Marital Status:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse's Name_____ Date of Birth_____/_____/_____
LAST FIRST M.I. MM DD YY

Employed by _____ Occupation_____

Employer Address _____

Family Dentist_____

Family Physician_____

Whom May We Thank For Referring You To Our Office? _____

Do you have Orthodontic Insurance? ❑ Yes ❑ No Name of Insurance Company_____

If responsible party is other than yourself, please give information: ❑ Not Applicable

Name_____ Relationship to Patient_____

Address _____ Tel.# (_____)_____

Does He or She have Orthodontic Insurance? ❑ Yes ❑ No Insurance Company_____

MEDICAL HISTORY:

Have you had or do you have any of the following?

	YES	NO		YES	NO
Rheumatic Fever	❑	❑	Persistent Headaches	❑	❑
Heart Murmur	❑	❑	Neck Pains	❑	❑
High Blood Pressure	❑	❑	Nerve or Brain Disease	❑	❑
Heart Attack/Stroke	❑	❑	Migraine	❑	❑
Blood Vessel Disease	❑	❑	Epilepsy	❑	❑
Blood Disorder	❑	❑	Autism/Asperger's Syndrome	❑	❑
AIDS/HIV Infection	❑	❑	ADD/ADHD	❑	❑
Hepatitis	❑	❑	Mental Health Problems	❑	❑
Diabetes	❑	❑	Bone Disorders	❑	❑
Ulcers	❑	❑	Arthritis	❑	❑
Herpes (Any Type)	❑	❑	Artificial Joints	❑	❑
Psoriasis	❑	❑	Sleep Apnea	❑	❑
Cancer	❑	❑	Ear Disorders	❑	❑
Sinus Infection	❑	❑	Swollen Glands	❑	❑
Allergies	❑	❑	Other _____		

Comments_____

Please List Any Other Significant Information About Your Medical History:

_____

_____

YES NO

❑ ❑ Are you under a physician's care at present? If yes, reason_____

❑ ❑ Are you presently, or have you ever been, under the care of a psychiatrist or psychologist? If yes, please describe_____

❑ ❑ Are you currently taking any medication? If yes, describe_____

❑ ❑ Are you allergic to any medications? (E.g.: aspirin, penicillin, etc.) If yes, what?_____

❑ ❑ Have you ever had any general anesthesia? When?_____

FEMALE PATIENTS

YES NO

❑ ❑ Do you have regular menstrual cycles?

❑ ❑ Have you experienced menopause?

❑ ❑ Has anyone in your family had osteoporosis?

❑ ❑ Is there a possibility that you could be pregnant?

DENTAL HISTORY

YES NO

❑ ❑ Do any of your teeth hurt? If yes, upper right ❑ upper left ❑ lower right ❑ lower left ❑

YES NO

❑ ❑ Have any wisdom teeth been removed? How many?_____

❑ ❑ Have you ever had treatment for periodontal disease (gum disease)?

If yes, describe _____

❑ ❑ Have you ever had any previous orthodontic treatment (braces)?

If yes, when _____ Length of Treatment? _____
If yes, doctor's name and address_____

❑ ❑ Have there been any injuries to your mouth or teeth?

If yes, describe _____

❑ ❑ Have you ever had any injury in the head and neck area?

If yes, describe _____

❑ ❑ Have you ever fallen and bumped your chin, or received a blow to your jaws?

If yes, describe_____

❑ ❑ Have you ever had any surgery in the head and neck area?

If yes, describe_____

❑ ❑ Do you clench or grind your teeth? If yes, while sleeping ❑ under stress ❑ other

❑ ❑ Do your jaw muscles ever feel tired? If yes, when_____

❑ ❑ Do you ever notice soreness, tightness or pain in the muscles around the jaw and face?

If yes, describe _____

YES NO

❑ ❑ Does it hurt to chew? If yes, where does it hurt?_____

❑ ❑ Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	RIGHT	LEFT	SINCE WHEN	DURING WHAT ACTIVITY
❑ Clicking	❑	❑	_____	_____
❑ Grating	❑	❑	_____	_____

Did these joint sounds begin gradually or suddenly? Gradually ❑ Suddenly ❑

❑ ❑ Was there some specific event that started the joint sounds?
If yes, describe _____

❑ ❑ Have you ever experienced difficulty in opening or closing your jaws?
If yes, describe _____

❑ ❑ Have your jaws ever "locked" closed? If yes, describe _____

❑ ❑ Have your jaws ever "locked" wide open? If yes, describe _____

❑ ❑ Do you have pain in your jaw joints? If yes, right ❑ left ❑ Since when? _____

Did your pain start gradually or suddenly? Gradually ❑ Suddenly ❑

What increases the pain?_____ What decreases the pain? _____

Do you have any of the following habits?

YES	NO	
❑	❑	Finger/Thumb sucking
❑	❑	Lip Biting
❑	❑	Nail Biting
❑	❑	Gum Chewing
❑	❑	Ice Chewing
❑	❑	Pen/Pencil Chewing

Please describe why you sought this consultation. What is your main concern?

_____

_____

Have you ever been treated for this problem before? If yes, please describe diagnosis and treatment.

_____

_____

Has any other member of the family had orthodontic treatment? Yes _____ No _____

Are there any other concerns not covered in this clinical history form? _____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

PATIENT OR PARENT'S SIGNATURE DATE

_____ _____

DOCTOR'S SIGNATURE DATE

Member American Association of Orthodontists

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