Karen E. Calef, DMD **Date________________**
211 Storrs Road Mansfield, CT 06250

Patient's Name:____ Date of Birth________________________
For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. **A thorough and complete history is vital to a proper orthodontic evaluation.**

Name Of Patient's Physician: ______________________________ Phone #: (_____)_____-_________
Physician's Addresss:____
Date Last Seen: __________ Reason: ____
Musical Interments Played: ______________________________ Sports and/or Hobbies: _______________________________
Number of brothers and sisters: _______ Ages: ______________________________
Birth Father's Height: _______ft. _______in. Birth Mother's Height: _______ft. _______in.
Patient's Birth Weight: _______lbs. _______oz. Patient's Present Weight: _______lbs. Height: _______ft. _______in.

PATIENT PROFILE

1. ☐**yes** ☐**no** ☐**dk/u** Does patient follow directions well?
2. ☐**yes** ☐**no** ☐**dk/u** Does patient brush his/her teeth conscientiously?
3. ☐**yes** ☐**no** ☐**dk/u** Does patient have learning disabilities or need extra help with instructions?
4. ☐**yes** ☐**no** ☐**dk/u** Is patient sensitive or self-conscious about teeth?
5. ☐**yes** ☐**no** ☐**dk/u** Is patient adopted?

MEDICAL HISTORY

Now or in the past has the patient had:

6. ☐**yes** ☐**no** ☐**dk/u** Birth defects or hereditary problems?
7. ☐**yes** ☐**no** ☐**dk/u** Bone fractures or any major accidents?
8. ☐**yes** ☐**no** ☐**dk/u** Back or neck problems?
9. ☐**yes** ☐**no** ☐**dk/u** Rheumatoid or arthritic conditions?
10. ☐**yes** ☐**no** ☐**dk/u** Artificial joints, disk replacements?
11. ☐**yes** ☐**no** ☐**dk/u** Endocrine or thyroid problems?
12. ☐**yes** ☐**no** ☐**dk/u** Kidney problems?
13. ☐**yes** ☐**no** ☐**dk/u** Diabetes?
14. ☐**yes** ☐**no** ☐**dk/u** Cancer, tumor, radiation treatment or chemotherapy?
15. ☐**yes** ☐**no** ☐**dk/u** Stomach ulcer or acidity?
16. ☐**yes** ☐**no** ☐**dk/u** Polio, mononucleosis, tuberculosis or pneumonia?
17. ☐**yes** ☐**no** ☐**dk/u** Persistent cough, cough up blood?
18. ☐**yes** ☐**no** ☐**dk/u** Problems of the immune system?
19. ☐**yes** ☐**no** ☐**dk/u** AIDS or HIV positive?
20. ☐**yes** ☐**no** ☐**dk/u** History of blood transfusion?
21. ☐**yes** ☐**no** ☐**dk/u** Blood disorder or disease?
22. ☐**yes** ☐**no** ☐**dk/u** Hepatitis, jaundice or liver problem?
23. ☐**yes** ☐**no** ☐**dk/u** Fainting spells, seizures, epilepsy or neurological problem?
24. ☐**yes** ☐**no** ☐**dk/u** Mental health disturbance or behavioral problem?
25. ☐**yes** ☐**no** ☐**dk/u** Vision, hearing, tasting or speech difficulties?
26. ☐**yes** ☐**no** ☐**dk/u** Loss of weight recently, poor appetite?
27. ☐**yes** ☐**no** ☐**dk/u** History of eating disorder? (anorexia/ bulimia)?
28. ☐**yes** ☐**no** ☐**dk/u** Excessive bleeding or bruising tendency, anemia or bleeding disorder?
29. ☐**yes** ☐**no** ☐**dk/u** High or low blood pressure?
30. ☐**yes** ☐**no** ☐**dk/u** Tires easily?
31. ☐**yes** ☐**no** ☐**dk/u** Chest pain, shortness of breath or swelling ankles?
32. ☐**yes** ☐**no** ☐**dk/u** Cardiovascular problem (heart trouble, heart attackangina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
33. ☐**yes** ☐**no** ☐**dk/u** Pacemaker, defibrillator, artificial heart valve?
34. ☐**yes** ☐**no** ☐**dk/u** Skin disorder?
35. ☐**yes** ☐**no** ☐**dk/u** Does the patient eat a well-balanced diet?
36. ☐**yes** ☐**no** ☐**dk/u** Frequent headaches, colds or sore throats?
37. ☐**yes** ☐**no** ☐**dk/u** Eye, ear, nose or throat condition? Includes tonsils and adenoids.
38. ☐**yes** ☐**no** ☐**dk/u** Hay fever, asthma, sinus trouble or hives?
39. ☐**yes** ☐**no** ☐**dk/u** Respiratory disease?

If YES to any of the above, note # and explain:__________________
____
____

Allergies or reactions to any of the following:

☐**yes** ☐**no** ☐**dk/u** Local anesthetics (Novocain or Lidocaine)
☐**yes** ☐**no** ☐**dk/u** Aspirin
☐**yes** ☐**no** ☐**dk/u** Ibuprofen (Motrin, Advil)
☐**yes** ☐**no** ☐**dk/u** Penicillin or other antibiotics
☐**yes** ☐**no** ☐**dk/u** Sulfa drugs
☐**yes** ☐**no** ☐**dk/u** Codeine or other narcotics
☐**yes** ☐**no** ☐**dk/u** Metals (jewelry, clothing snaps)
☐**yes** ☐**no** ☐**dk/u** Latex (gloves, balloons)
☐**yes** ☐**no** ☐**dk/u** Vinyl
☐**yes** ☐**no** ☐**dk/u** Acrylic
☐**yes** ☐**no** ☐**dk/u** Animals
☐**yes** ☐**no** ☐**dk/u** Food (specify) _____________
☐**yes** ☐**no** ☐**dk/u** Other substances (specify) ______________
☐**yes** ☐**no** ☐**dk/u** Does the patient currently have or ever had a substance abuse problem?
☐**yes** ☐**no** ☐**dk/u** Does patient chew or smoke tobacco?
☐**yes** ☐**no** ☐**dk/u** Operations? Describe: _____________________
☐**yes** ☐**no** ☐**dk/u** Hospitalized? For: _______________________
☐**yes** ☐**no** ☐**dk/u** Other physical problems or symptoms? Describe:
____

☐**yes** ☐**no** ☐**dk/u** Is the patient taking medications, nutrient supplements, herbal medications or non-prescription medicine? Please name them:
Medication______________ Taken for________________________
Medication______________ Taken for________________________
Medication______________ Taken for________________________

☐**yes** ☐**no** ☐**dk/u** Being treated by another health care professional? (including behavioral, psychosocial, or mental health issues? For:
____
Date of most recent visit_____________________
Are there any other medical conditions we should be aware of? ____
____

GIRLS ONLY

☐yes ☐no ☐dk/u Has the patient started her monthly periods?
If so, approximately when? _________________
☐yes ☐no ☐dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain:

Bleeding disorders ____
Diabetes ____
Arthritis ____
Metabolic disturbances _____________________________________
Severe allergies ____
Unusual dental problems ____________________________________
Jaw size imbalance ____
Congenitally missing teeth ___________________________________
Root resorption ____
Other family members, including parents, treated orthodontically _____
____
Any other family medical conditions that we should know about? _____
____

DENTAL HISTORY

Now or in the past has the patient had:

☐yes ☐no ☐dk/u Started teething very early or late
☐yes ☐no ☐dk/u Primary (baby) teeth removed that were not loose?
☐yes ☐no ☐dk/u Permanent or supernumerary (extra) teeth removed?
☐yes ☐no ☐dk/u Supernumerary (extra) or congenitally missing teeth?
☐yes ☐no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐yes ☐no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐yes ☐no ☐dk/u Jaw fractures, cysts or mouth infections?
☐yes ☐no ☐dk/u Growths in mouth?
☐yes ☐no ☐dk/u "Dead teeth" or root canals treated?
☐yes ☐no ☐dk/u Root resorption?
☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?
☐yes ☐no ☐dk/u Periodontal "gum problems"?
☐yes ☐no ☐dk/u Food impaction between teeth?
☐yes ☐no ☐dk/u Thumb, finger, or sucking habit?
Until what age? _____
☐yes ☐no ☐dk/u Abnormal swallowing habit (tongue thrusting)?
☐yes ☐no ☐dk/u History of speech problems?
☐yes ☐no ☐dk/u Mouth breathing habit, snoring or difficulty in breathing?
☐yes ☐no ☐dk/u Tooth grinding, jaw clenching clicking or locking?
☐yes ☐no ☐dk/u Any pain in the jaw or ringing in the ears?
☐yes ☐no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?
☐yes ☐no ☐dk/u Difficulty encountered in chewing or jaw opening?
☐yes ☐no ☐dk/u Aware of loose, broken or missing restorations (fillings)?
☐yes ☐no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?
☐yes ☐no ☐dk/u Concerned about spaced, crooked, or protruding teeth?
☐yes ☐no ☐dk/u Concerned about under or over developed jaw?
☐yes ☐no ☐dk/u "Gum Boils", frequent canker sores or cold sores?
☐yes ☐no ☐dk/u Taking any form of fluoride?
☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?
☐yes ☐no ☐dk/u Had periodontal (gum) treatment?
☐yes ☐no ☐dk/u Would patient object to wearing any orthodontic appliances (braces) should they be indicated?
☐yes ☐no ☐dk/u Any serious trouble related to previous dental treatment?
☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?
☐yes ☐no ☐dk/u Been under another dentist's care?
Specialist_______________________________
Other_________________________________

Name Of Patient's Dentist: ____ Phone# _______________________________
Dentist's Address: ____
Date Last Seen: __________ Reason: ____

How often does your child brush? ______________ Floss? _______________

What is your primary concern? Why are you here?
____
____

I have read and understand the above questions. I will not hold my orthodontist or any other member or his/her staff responsible for any errors or
omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed:____ Date signed:________________
(Parent or Guardian)

Signed:____ Date signed:________________
(Dental Staff Member)

Dr. Karen E. Calef

211 Storrs Rd. Mansfield, CT 06250 **(860) 456-3718** **www.smilesbykaren.com**

RESPONSIBLE PARTY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

CONFIDENTIAL

Date: __________________

PATIENT INFORMATION

Patient's Last Name: __________________ First Name: __________________ Prefers To Be Called:__________________

Birth Date: ____________ Age: ________ Gender: ☐Male ☐Female Home Phone #: (______) ____________________

Patient's Mailing Address:____

Residence address (if different): ____

Who Does Patient Live With? ______________________________________Grade: ______ Attends School At _____________

CUSTODIAL PARENT INFORMATION

Custodial Parent(s) or Guardian(s): ____

Address (if different than patient's): ____

E-mail Address: ____

Preference for receiving calls: 1, 2, 3 in parentheses:

Phone # Home: (_____)_____________( ) Cell: (_____)_____________( ) Work: (_____)_____-________( )

RESPONSIBLE PARTY INFORMATION E-Mail address:____

Who Is Financially Responsible For This Account? Last Name: ___________________ First Name: ____________________

DOB:________________________Address:____

Years At This Address: _____ If Less Than Five Years, Previous Address: ____

S.S.N: _________________________ Phone # Home: (____)___________Cell: (____)___________Work: (____)_________

Employer: ________________________ ______________________________________ Date Employed: ______________

PATIENT'S INSURANCE INFORMATION

Insurance Coverage for Dental Treatment? ☐ yes ☐ no Insurance Coverage for Orthodontic Treatment? ☐ yes ☐ no

Subscribers Name: ______________________________________ Relationship: _______________ D.O.B. _________________

Employer Name: _____________________ Address: ____________________________________Date employed___________

Insurance Company: _____________________________________ Group #: __________________ S.S.N: _________________

Insurance Company Address & phone#: ____

Secondary Policy Holder's Name: __________________________ Relationship: _________________D.O.B________________

Employer Name: _____________________ Address: ____________________________________Date employed__________

Insurance Company: _____________________________________ Group #: __________________ S.S.N: _________________

Insurance Company Address & phone #: ____

How did you hear about our office? ____

Who suggested your child may need orthodontic treatment? ____

"I hereby authorize DentalBanc, LLC, on behalf of Dr. Calef to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options."

NOTE: "Obtaining a DentalBanc credit recommendation does not alter the responsible party's credit score in any way"

Signature: _______________________________ Printed name: __________________________ Date: ______________

Your Signature below authorizes Dr. Karen Calef to bill your insurance company and make benefits payable to our office. Please be aware that you are responsible for the entire account, although we will be more than happy to process your insurance claims. We are third party to your insurance company and can only provide you with estimates. It is your responsibility to have knowledge of your insurance benefit including eligibility, maximums and deductibles.

The undersigned hereby promises to pay for all services rendered by Dr. Karen Calef's office. On default of any payment due the undersigned further agrees to pay the cost of collection, including reasonable Attorney's fees and court costs. Appointments cancelled or failed without 24 hours advanced notice are subject to charge.

Signature of responsible party: ____ Date: ______________