Greenwich Braces, LLC

Adult Patient's Clinical History/Family Information

Patient's Name_____ Age _____ Sex____ Birthdate_____
Last First M.I.

Address_____ Telephone # (____)_____
Street City Zip

S.S. # of Patient_____

Employed by_____ Occupation_____ Position_____

Best telephone number to call for appointments **(During Business Hours)**_____

Fax #_____ Cell Phone # _____ E-mail Address_____

Financially Responsible Party _____

Name_____

Home Address_____ Home Tel. # (___)_____

Employed by_____ Occupation_____ Position_____

Office Address_____ Work Tel. # (____)_____

General Dentist_____ Tel. #_____

Whom may we thank for referring you to our office?_____

Emergency Information Contact (in case of an emergency)
Name_____ Tel. # _____ Relationship_____

Does responsible party have Orthodontic Insurance? o Yes o No

MEDICAL HISTORY:

Patient's general health: o Excellent o Good o Fair o Poor

Last complete physical: Date ___/___/___

Has patient had or does patient have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	o	o	Persistent Headaches	o	o
Heart Murmur	o	o	Neck Pains	o	o
High Blood Pressure	o	o	Nerve or Brain Disease	o	o
Heart Attack/Stroke	o	o	Migraine	o	o
Blood Vessel Disease	o	o	Epilepsy	o	o
Blood Disorder	o	o	Mental Health Problems	o	o
AIDS/HIV Infection	o	o	Bone Disorders	o	o
Hepatitis	o	o	Arthritis (any type)	o	o
Diabetes	o	o	Sleep Apnea	o	o
Ulcers	o	o	Ear Disorder	o	o
Herpes (any type)	o	o	Sinus Infection	o	o
Psoriasis	o	o	Swollen Glands	o	o
Cancer	o	o	Allergies	o	o

Comments_____

Please list any other significant information about the patient's medical history:

_____

Have you ever been hospitalized? ____If yes, for_____

Yes	No	
o	o	Is patient under a physician's care at present? If yes, reason _____
o	o	Is patient currently taking any medication? If yes, describe_____

o o Is the patient allergic to any medications? (Ex.: aspirin, penicillin, etc.) If yes, what?____

o o Has patient ever had any general anesthesia? When?_____

o o Does patient need to Pre-Medicate?

DENTAL HISTORY

Last dental check-up: Dr._____ Date ___/___/___

Yes	No	
o	o	Does the patient gag easily?
o	o	Have you ever had treatment for a periodontal disease (gum disease)? If yes, when_____
o	o	Have you ever had any previous orthodontic treatment (braces)? If yes, when_____
		If yes, doctor's name and address_____
o	o	Have there been any injuries to your mouth or teeth? If yes, describe_____
o	o	Have you ever been any injury in the head and neck area? If yes, describe_____
o	o	Do you clench or grind your teeth? If yes, while sleeping or under stress or other_____
o	o	Do your jaw muscles ever feel tired? If yes, when_____
o	o	Do you hear clicking (popping) or grating sounds in you jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
o Clicking:	o	o	_____	_____
o Grating:	o	o	_____	_____

Did these joints begin gradually or suddenly: gradually o suddenly o

o	o	Was there some specific event that started the joints sounds? If yes, describe_____
o	o	Have you ever experienced difficulty in opening or closing your jaws?

Yes	No	
o	o	Have your jaws ever "locked" closed? If yes, describe_____
o	o	Have your jaws ever "locked" wide open? If yes, describe_____
o	o	Do you have pain in your jaws joints? If yes, right o left o since when?_____

Do you have any of the following habits?

Yes	No	
o	o	Finger/Thumb sucking
o	o	Nail or Lip Biting
o	o	Tongue thrust habit
o	o	Gum Chewing
o	o	Ice Chewing

Please describe why you sought this consultation_____

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 changed to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also authorize Dr. Ryan, and staff to perform all the necessary procedures deemed appropriate to make a thorough diagnosis of the patient's dental and oral facial needs.

_____ _____

Signature of Patient Date

Rosemary Ryan, D.D.S., L.L.C.
4 Dearfield Drive, Suite 204
Greenwich, CT 06831
Office 203-869-2044
Fax 203-869-5172

Appointment Reminders

We offer appointment reminders by email **OR** text, please choose one. If you are interested please complete the information below and return to the office. If you are not interested we will continue to call the number given.

Please choose one

For email reminder

Patient Name _____

Email Address _____

For text reminder

Cellular phone no. _____

Consent for Orthodontic Patients and Parents

As a rule, desirable orthodontic results can be achieved with informed and cooperative patients. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some inherent risks and limitations. These are seldom enough to refrain from treatment but should be considered in making the decision to wear orthodontic appliances. Please feel free to ask any questions.

Proper oral hygiene and plaque removal is a must! Sugars and between meal snacks should be eliminated, as well as very hard or sticky foods. Decalcification (permanent markings), decay, or gum disease can occur if patients do not brush their teeth properly and thoroughly during the treatment period. I recommend that all patients continue to see their family dentist before and during orthodontic treatment for routine dental care.

My goal is to achieve a functional occlusion in every patient. However, in dealing with human beings and problem of growth and development, as well as genetics and patient cooperation, 100% achievement of this goal is not always possible. Therefore, a functionally adequate and esthetically acceptable result must be deemed successful.

It is also important to realize that throughout life, tooth position is constantly changing. This is true with all individuals regardless of whether they have had orthodontic treatment or not. Post-orthodontic patients are subject to the same changes that occur in non-orthodontic patients.

Discoloration and/or dead teeth are seldom related to orthodontic treatment. On occasion, the nerve of the tooth may become non-vital. A tooth that has been traumatized from deep filing or even a major blow can die over a long period of time, with or without orthodontic treatment. A non-vital tooth may flare up during orthodontic movement. Subsequent endodontic (root canal) treatment may be necessary to maintain it.

In some cases, the root ends of the teeth may shorten during treatment. This is called root resorption. Under healthy circumstances, the shortened roots are of little disadvantage. It should be noted that not all root resorption arises from orthodontic treatment. Trauma cuts, impaction, endocrine disorders or unknown reasons can also cause root resorption.

There is also a slight risk that problems may arise in temporomandibular joints (TMJ). Although this is not common, it is a possibility. Tooth alignment or bite correction may improve tooth-related causes of TMJ pain, but not in all cases. Everyday tension appears to play a role in frequency and severity of joint pains.

Occasionally, a person who has grown normally and in average proportions may not continue to do so. If growth becomes disproportionate, the jaw relation can be affected and original treatment objectives may have to be altered. Skeletal growth disharmony is a biological process, which may be beyond the orthodontist's control.

Headgear instructions must be followed carefully. A headgear that is removed while the force is attached can snap back and result in serious injury to the face or eyes. Be sure to release the headgear carefully in the sequence as instructed in our office. Lets make every effort to do this right! It takes cooperation from everyone – orthodontist and staff – as well as the patient and his or her family.

Thank you, in advance for your cooperation in this matter

PATIENT'S NAME_____

PARENT OR GUARDIAN_____

ADDRESS_____

SIGNATURE_____**DATE**_____

THIS FORM HAS BEEN APPROVED BY THE CONNECTICUT SOCIETY OF ORTHODONTICS