



Dr. Paul J. Styr, Inc.
ORTHODONTICS

Welcome

Welcome to our office! Our goal is to make every visit pleasant and educational for you. Please don't hesitate to ask us a question or let us know how we can make your visit more comfortable. We provide the highest quality care and personal service possible and we know that the better we communicate with you, the better we can serve you. **We look forward to working together to give you the smile you've always dreamed of having...**in less time than you ever imagined.

Tell Us About You

Today's Date: _____ Male Female

Name: _____
LAST FIRST M.I.

I prefer to be called: _____

Birthdate: _____ Age: _____

SS#: _____ DL#: _____

Home Address: _____

CITY STATE ZIP

Home #: _____ Mobile/Pager: _____

Work #: _____ Ext: _____

Employer: _____

Employer Address: _____

CITY STATE ZIP

Year started? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Name of General Dentist: _____

Last visit date: _____

Spouse Information

His/Her Name: _____

Employer: _____

Work #: _____ Ext.: _____ SS#: _____

DL#: _____ Birthdate: ____/____/____

Emergency Contact Information:

Name: _____ Relation: _____

Work #: _____ Ext: _____ Home #: _____

Person Responsible For Account

Name: _____

Billing Address: _____

CITY STATE ZIP

Previous Address: _____

CITY STATE ZIP

Work #: _____ Ext: _____ Home #: _____

Employer: _____

SS#: _____ DL#: _____

Primary Dental/Orthodontic Insurance

Orthodontic Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ____/____/____

Insured's SS#: _____

Insured's Employer: _____

Secondary Dental/Orthodontic Insurance

Orthodontic Coverage: Yes No

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ____/____/____

Insured's SS#: _____

Insured's Employer: _____



Medical History

Do you have a personal physician? Yes No
 Physician's Name: _____
 Phone #: _____
 Date of last visit: _____
Your current physical health is: Good Fair Poor
 Are you currently under a physician's care? Yes No
 Please explain: _____
 Are you taking any prescription/over-the-counter drugs? Yes No
 Please list each one: _____

For women: Are you taking birth control pills? Yes No
 Are you pregnant? week# _____ Yes No
 Are you nursing: Yes No

- Have you had any of the following diseases/medical problems?**
- | | |
|---------------------------------------|----------------------------------|
| Y N Anemia/Radiation Treatment | Y N Heart Surgery/Pacemaker |
| Y N Artificial Bones/Joints | Y N Hemophilia/Abnormal Bleeding |
| Y N Artificial Valves | Y N Hepatitis |
| Y N Asthma/Arthritis | Y N High/Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV+/AIDS |
| Y N Cancer/Chemotherapy | Y N Hospitalized for any reason |
| Y N Congenital Heart Defect | Y N Kidney Problems |
| Y N Diabetes/Tuberculosis (TB) | Y N Mitral Valve Prolapse |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug/Alcohol Abuse | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema/Glaucoma | Y N Severe/Frequent Headaches |
| Y N Epilepsy/Seizures/Fainting Spells | Y N Shingles |
| Y N Fever Blisters/Herpes | Y N Sinus Problems |
| Y N Heart Attack/Stroke | Y N Ulcers/Colitis |
| Y N Heart Murmur | Y N Venereal Disease |

Please list any medical condition(s) that you have had:

Are you allergic to any of the following:

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin
Y N Any Metal/Plastic	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

Please list any other drugs that you are allergic to:

Dental History

What are the main concerns that you would like orthodontics to accomplish:

Have you ever had or been evaluated for orthodontic treatment before? Yes No
 Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Have you ever experienced pain, discomfort or tenderness in jaw joints (TMJ/TMD)? Yes No
 Your current dental health is: Good Fair Poor

- Do you like your smile? Yes No
 - Do your gums ever bleed? Yes No
 - Have you ever injured your mouth? Yes No
 - Have you ever injured your teeth? Yes No
 - Have you ever injured your chin? Yes No
 - Do you have any speech problems? Yes No
- Please list speech problems:

Do you generally breathe through your mouth?
 While awake? Yes No
 While asleep? Yes No

Do you have any missing or extra permanent teeth? Yes No

Our office is committed to meeting or exceeding
 the standards of infection control mandated by OSHA,
 the CDC, and the ADA.

Consent and Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or personal information. I authorize the orthodontic staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent.

 Signature Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

 Signature Date