

Welcome to the office of Drs. Cassinelli and Shanker

Our mission is to treat each individual with care, dignity and compassion, to base all treatment decisions on scientific knowledge, and to be evidence-based and patient-centered in all of our clinical care. Above all, our goal is to obtain excellence in all that we do.

Tell Us About Your Child

Child's Name

Today's Date _____

Last _____ First _____ MI _____

Child's Nickname _____ Ethnicity _____

Birth Date ____/____/____ Age _____ Male Female

Child's Home # _____

Child's Home Address

Grade _____ School _____

Hobbies/Sports _____

Child's Dentist _____ Physician _____

Other Family Members Treated by our office _____

From Whom did you first hear of our office? _____

Mother's Information

Step Mother Guardian

Name _____ Birth Date _____

Home # _____ Email _____

Home Address _____

APT/CONDO # _____

CITY _____ STATE _____ ZIP _____

Employer _____ Position _____

Wk # _____ Cell # _____

SS # _____ Do you have Orthodontic Insurance? Yes No

Father's Information

Step Father Guardian

Name _____ Birth Date _____

Home # _____ Email _____

Home Address _____

APT/CONDO # _____

CITY _____ STATE _____ ZIP _____

Employer _____ Position _____

Wk # _____ Cell # _____

SS # _____ Do you have Orthodontic Insurance? Yes No

Parent's Marital Status Married Divorced Separated

Single Widowed

Person Responsible For Account

Name _____ Relationship _____

Billing Address _____
APT/CONDO # _____

CITY _____ STATE _____ ZIP _____

Home # _____ Cell # _____

Employer _____ Position _____

Work # _____ SS # _____

I understand that I am responsible for payment of services rendered.

Signature of responsible party (This is typically the resident parent) Date

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the dental/orthodontic staff to perform the necessary dental/orthodontic services my child may need.

Signature of parent or guardian Date

PLEASE COMPLETE THE DENTAL INSURANCE INFORMATION FORM IF YOU HAVE DENTAL INSURANCE WHICH HAS ORTHODONTIC COVERAGE

If this office accepts insurance, I hereby authorize and direct payment of the dental/orthodontic benefits directly to this office.

Signature of Primary Insurance Owner Date

Signature of Secondary Insurance Owner Date

Emergency Contact

Name _____ Relationship _____

Home # _____ Wk # _____

Cell # _____

Dental History

The answers to the following questions are for office records only and will be considered confidential.
A thorough and complete history is vital to a proper orthodontic evaluation.

Yes No DK/U For the following questions mark Yes, No, or Don't Know/Understand.

- ___ ___ ___ Does patient have difficulty following directions?
___ ___ ___ Does patient have difficulty brushing his/her teeth conscientiously?
___ ___ ___ Does patient have a strong gag reflex?
___ ___ ___ Does patients have learning disabilities or need extra help with instructions?
___ ___ ___ Is patient sensitive, self-conscious?
___ ___ ___ Supernumerary (extra) or congenitally missing teeth?
___ ___ ___ Permanent or "extra" teeth removed?
___ ___ ___ Chipped or otherwise injured primary (baby) or permanent teeth?
___ ___ ___ Periodontal "Gum problems" or treated for periodontal problems?
___ ___ ___ Thumb, finger or sucking habit? Until age _____
___ ___ ___ History of speech problems?
___ ___ ___ Mouth breathing habit, snoring, difficulty in breathing?
___ ___ ___ Any relative with similar tooth or jaw relationships?
___ ___ ___ Onset of puberty?
 Females onset of menstruation (approximate date) _____
 Males onset of voice change (approximate date) _____
___ ___ ___ Has patient ever had a prior orthodontic examination or treatment?
If so, when/where? _____

___ ___ ___ Would patient object to wearing orthodontic appliances (braces) should they be recommended?

Date of most recent dental examination _____

How often does patient brush? _____ Floss? _____

What is the patient, parent or referral sources' primary concern?
(What brought you here?)

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? If so please list:

Medical Alert Summary – Office Use Only

- Yes No DK/U (if yes please circle)
- ___ ___ ___ Birth defects or hereditary problems?
- ___ ___ ___ Rheumatoid or arthritic conditions?
- ___ ___ ___ Endocrine or thyroid problems?
- ___ ___ ___ Kidney problems?
- ___ ___ ___ Diabetes?
- ___ ___ ___ Cancer or been treated for a tumor?
- ___ ___ ___ Stomach ulcer or hyperacidity?
- ___ ___ ___ Polio, mono, tuberculosis, pneumonia?
- ___ ___ ___ Problems of the immune system?
- ___ ___ ___ AIDS or HIV positive?
- ___ ___ ___ Sexually Transmitted Diseases?
- ___ ___ ___ Hepatitis, jaundice or liver problem?
- ___ ___ ___ Fainting spells, seizures, epilepsy or neurologic problem?
- ___ ___ ___ Mental health or behavioral problem, including ADHD, bipolar, depression?
- ___ ___ ___ Vision, hearing, tasting or speech difficulties?
- ___ ___ ___ Loss of weight recently, poor appetite?
- ___ ___ ___ Excessive bleeding, black and blue tendency, anemia or bleeding disorders?
- ___ ___ ___ High or low blood pressure?
- ___ ___ ___ Tires easily?
- ___ ___ ___ Chest pain, shortness of breath or swelling ankles?
- ___ ___ ___ Cardiovascular problem (heart trouble), heart murmur, heart attack, angina, coronary insufficiency, stroke, inborn heart defects or rheumatic heart? If yes please list:

- ___ ___ ___ Is premedication required for cardiovasclar problem?
- ___ ___ ___ Do you have a poor or altered diet?
- ___ ___ ___ Frequent headaches, colds or sore throats?
- ___ ___ ___ Eye, ear, nose or throat condition?
- ___ ___ ___ Hayfever, sinus trouble, hives?
- ___ ___ ___ Asthma?

- Yes No DK/U (if yes please circle)
- ___ ___ ___ Tonsil or adenoid conditions?
- ___ ___ ___ Allergies or drug reactions?
- ___ ___ ___ Known Drug Allergies.

- ___ ___ ___ Are you taking medication, nutrient supplements or non-prescription medicine? Please list them:

- ___ ___ ___ Do you or have you taken a Bisphosphonate* drug?
- ___ ___ ___ Does the patient currently have or ever had a substance abuse problem?
- ___ ___ ___ Operations? _____
- ___ ___ ___ Hospitalized for:

- ___ ___ ___ Other physical problems or symptoms?

- ___ ___ ___ Being treated by another health care professional?
For _____

Date of latest physical exam? _____
Weight _____ Height _____

Medical History Update: Indicate changes in pubertal status (voice change-boys, menstruation- girls)- please date & initial onset: _____

Any additional medical information we should be aware of that may impact treatment:

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

Signature of parent or guardian Date
*Actonel, Boniva, Fosamax, Fosamax Plus D, Skelid, Didronel, Aredia, Zometa, or Bonefos