Goodman Orthodontics

Orthodontics for Adults & Children — 440 East 57th Street, New York, NY 10022

Name:	☐ M ☐ F	Today's Date: / /
Address :		
City/State/Zip:		Birth Date: / / Age
Cell Phone:	Referred by:	
E-Mail Address:		
Work Phone:		
Employer / School		
Business Address:		
General Dentist:		Dentist Phone Number:
Approximate date of last dentist visit:	For what service?	
Any incidents of trauma to the dentition?	☐Yes ☐No	Describe the injury:
Have you ever had orthodontic treatment in the past?		☐ Yes ☐ No
Do you suffer from painful chewing muscles, jaw pain, or TMJ?		☐ Yes ☐ No
Are you aware of grinding or clenching your teeth?		☐ Yes ☐ No
What is your particular concern about your teeth:		

GENERAL HEALTH HISTORY

Physician:	Physician Phone Number:
Do you require Antibiotic Prophylaxis for dental procedures, or do you have a heart murmur or prosthetic valve?	☐ Yes ☐ No Explain:

Are you allergic to any medication? ☐ Yes ☐ No Explain:

Have you taken Bisphosphonates (Boniva, Fosamax, etc..) ☐ Yes ☐ No

Check below if you have any history of, or difficulty with any of the following:

If **none** of the below conditions apply, please check here ☐

☐ Anemia	☐ Chronic sinus	☐ Bleeding Disorders	☐ Hearing	☐ Malignancies
☐ Asthma	☐ Convulsions	☐ Fainting	☐ Intestinal	☐ Mononucleosis
☐ Canker Sores	☐ Diabetes	☐ Heart	☐ Kidney	☐ Skin
☐ HIV +	☐ Hepatitis	☐ Oral herpes	☐ Headaches	☐ Mitral Valve Prolapse

Any history or conditions not mentioned above, which might relate to orthodontic treatment:

Signature:	Date :