VICTORIA LYNSKEY
Orthodontist

1. About You

Name: _____

I prefer to be called: _____

Birthdate: _____ ☐ M ☐ F ☐ Other

Preferred pronouns: _____

Email address: _____

SSN: _____

Home address: _____

City: _____ State: _____ ZIP: _____

☐ Single ☐ Partnered ☐ Married ☐ Divorced

☐ Widowed ☐ Separated

Home #: _____

Cell: _____

Employer: _____

Occupation: _____

Whome may we thank for referring you? _____

Other family members seen by us? _____

General dentist: _____

Last visit date: _____

2. Spouse Information

Name: _____

Occupation: _____

Employer: _____

Home #: _____ Cell: _____

Email: _____

3. Billing Information

Person(s) responsible for the account: _____

Billing address: _____

_____

Relationship: _____ SSN: _____

4. Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's name: _____

Phone #: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relationship: _____ Wk #: _____

4. Insurance Information

Insurance company name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Adult Coverage? ☐ Yes ☐ No

Subscriber: _____ SSN: _____

Subscriber Birthdate: _____ Group #: _____

95 Montgomery Drive, Suite 220 • Santa Rosa, CA 95404 • P: 707.525.1180 • F: 707.525.1554 • **stunningsmile.com**

6. Medical History

Your current medical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Are you taking any prescription or over-the-counter drugs?
☐ Y ☐ N

Please list each one: _____

_____

For Women:
Are you taking birth control pills? ☐ Y ☐ N
Are you pregnant? ☐ Y ☐ N Weeks #: _____
Are you taking birth control pills? ☐ Y ☐ N
Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems?

☐ Y ☐ N Anemia
☐ Y ☐ N Artificial Bones / Joints / Valves
☐ Y ☐ N Arthritis/Osteoporosis/Bisphosphonates
☐ Y ☐ N Blood Transfusion
☐ Y ☐ N Cancer / Chemotherapy
☐ Y ☐ N Congenital Heart Defect / Heart Murmur
☐ Y ☐ N Diabetes
☐ Y ☐ N Difficulty Breathing / Asthma / Hayfever / Sinus
☐ Y ☐ N Emphysema / Glaucoma
☐ Y ☐ N Epilepsy / Seizures / Fainting Spells
☐ Y ☐ N Fever Blisters / Herpes
☐ Y ☐ N Heart Attack / Stroke / Surgery / Pacemaker
☐ Y ☐ N Hemophilia / Abnormal Bleeding
☐ Y ☐ N Hepatitis / Jaundice / Liver Problems
☐ Y ☐ N High / Low Blood Pressure
☐ Y ☐ N Immunocompromised
☐ Y ☐ N Hospitalized for any reason
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Mitral Valve Problems
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Rheumatic / Scarlet Fever
☐ Y ☐ N Severe / Frequent Headaches
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Tonsils or Adenoids Removed (Age: _____)
☐ Y ☐ N Tuberculosis (TB)
☐ Y ☐ N Ulcers / Colitis
☐ Y ☐ N Venereal Disease
☐ Y ☐ N Sensory Processing Issues Type: _____

Please list any serious medical condition(s) you've had:

_____

Are you allergic to the following:

☐ Y ☐ N Aspirin
☐ Y ☐ N Metal / Plastics
☐ Y ☐ N Codeine
☐ Y ☐ N Anesthetics
☐ Y ☐ N Erythromycin
☐ Y ☐ N Latex
☐ Y ☐ N Penicillin
☐ Y ☐ N Tetracycline

7. Dental History

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

What are the main concerns that you would like to address?

_____

_____

_____

☐ Y ☐ N Have you ever had/been evaluated for orthodontics?
☐ Y ☐ N Have you ever had a serious/difficult problem associated with any previous dental work?
☐ Y ☐ N Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)?
☐ Y ☐ N Do you want to improve your smile?
☐ Y ☐ N Do your gums ever bleed?
☐ Y ☐ N Have you ever injured your ☐ Mouth ☐ Teeth ☐ Chin
☐ Y ☐ N Do you have any speech problems?
☐ Y ☐ N Do you grind your teeth?
☐ Y ☐ N Do you generally breathe through your mouth?
☐ Y ☐ N Do you generally breathe through your mouth while asleep?
☐ Y ☐ N Do you snore or have restless sleep?
☐ Y ☐ N Do you experience excessive tiredness during the day?
☐ Y ☐ N Do you have a family member with sleep apnea?
☐ Y ☐ N Do you have any extra or missing permanent teeth?
☐ Y ☐ N Do you have more than one bite?
☐ Y ☐ N Do you have problems chewing gum?
☐ Y ☐ N Do you have problems chewing sticky/chewy foods?
☐ Y ☐ N Have your teeth changed in the last five years?

8. Authorization

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 confidence and it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

My records may be used for teaching or research ☐ Y ☐ N

_____
Patient Signature Date

_____
Lynskey Othodontics Staff Signature Date