Springfield Orthodontics

Emily J. Samuel, DMD, MMSc

368 River Street, Suite 100, Springfield, VT 05156

(802) 886-2552

Welcome to our office! Thank you for answering these questions.

Full Legal Name _____ Nickname_____
First Middle Last

Sex: M _____ F _____ Date of Birth _____ Age _____ Social Security #_____

Home Address _____ Town _____ State _____ Zip Code _____

Mailing Address *(if different)* _____ Town _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Dentist _____ Date of Last Visit _____

Physician _____ Date of Last Visit _____

Employer Name & Address _____

Occupation _____ Work Phone _____

Hobbies and interests _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

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

Do you have insurance which may cover orthodontics? _____

(If yes, please fill out green insurance information sheet)

Orthodontic Concerns

What is the orthodontic problem as you see it? _____

Indicate your concern for correcting the problem:

Very concerned _____ Concerned _____ Indifferent _____ Opposed _____

Normal stress level: High _____ Medium _____ Low _____

Does anyone in the family have similar dental or facial conditions? _____ Who _____

Oral Habits	***Yes***	***No***
Lip or cheek biting	☐	☐
Mouth breathing	☐	☐
Tooth clenching or grinding	☐	☐
Speech difficulties	☐	☐

OVER →

Medical History and Habits

	Yes	*No*
Are you in good health?	☐	☐
If not, please explain		
Have there been any changes in your general health within the past year?	☐	☐
Have you had any serious illnesses or operations?	☐	☐
If so, what was the problem		
Are you being treated for any medical condition?	☐	☐
If yes, for what condition		
Have you been hospitalized in the last five years?	☐	☐
If so, for what reason		
Are you taking any medication?	☐	☐
If so, what?	☐	☐
Do you have any allergies?	☐	☐
☐Asthma ☐Latex ☐Nickel/Metal ☐Drug ☐Other		
Do you suffer from frequent or recent strep throat?	☐	☐
Do you suffer from frequent headaches and/or jaw pain or noises?	☐	☐
Have you had any history of accident/trauma to face or teeth?	☐	☐
If so, please explain		
Have you ever had a bad experience at a dental office?	☐	☐
Women: Are you pregnant now?	☐	☐

Do you have a history of any of any of the following?

	Yes	*No*		*Yes*	*No*
Heart problems	☐	☐	Anemia	☐	☐
Rheumatic fever/rheumatic heart disease	☐	☐	Cancer	☐	☐
Heart murmur	☐	☐	Respiratory disease	☐	☐
Diabetes	☐	☐	Liver disease	☐	☐
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐
Sores on lips or in mouth	☐	☐	Stomach/intestinal problems	☐	☐
Hepatitis	☐	☐	Impaired hearing	☐	☐
Tuberculosis	☐	☐	Impaired vision	☐	☐
HIV Infection	☐	☐	Mental health problems	☐	☐
Aids	☐	☐	Attention Deficit Disorder (ADD)	☐	☐
Thyroid disease	☐	☐	Obsessive Compulsive Disorder (OCD)	☐	☐
Prolonged bleeding	☐	☐	Other	☐	☐

Additional Comments

SIGNATURE: _____

PRINT NAME: _____

DATE: _____