

Welcome to our Office

So that we may become better acquainted, please complete the following:

Donald R. Joondeph, D.D.S., M.S.

Diplomate of the American Board of Orthodontics

Patient's Name: _____ Account # _____

Address: _____ City: _____ Zip: _____

Age: _____ Date of Birth: _____ Home Phone: (____) _____

Living with: Both Parents Mother Father Other _____

Father's Name: _____ SS#: _____ Email: _____

Father's Employer: _____ Day Phone: (____) _____ Cell: (____) _____

Mother's Name: _____ SS#: _____ Email: _____

Mother's Employer: _____ Day Phone: (____) _____ Cell: (____) _____

Person Responsible for Account (if other than above): _____

Address: _____ City: _____ Zip: _____

Day Phone: (____) _____ SS#: _____

Patient's Dentist: _____ Patient's Physician: _____

Orthodontic Insurance? Yes No Who may we thank for this referral? _____

Has an Orthodontist been consulted previously? _____

Reason for seeking treatment? _____

Medical History: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information. Contact our office immediately if the medical information changes. **If YES to any questions, please specify.**

Have you ever had:	Yes	No
Asthma, Hay Fever, Sinusitis, or Other Allergies?		
Allergy to Penicillin, Aspirin, Local or General Anesthetic, or Other Drugs?		
Blood Pressure or Heart Problems?		
Rheumatic Fever or Heart Murmur?		
A Pacemaker or Open Heart Surgery?		
Diabetes, Liver, Kidney, Thyroid or Lung Problems?		
Ulcers or Stomach Problems?		
Epilepsy or Nervous Disorders?		
Arthritis, or is there a family history of Arthritis?		
Bleeding or Clotting Disorders?		
Herpes, HIV?		
Any Other Illnesses - Please Describe		
1. Are you presently taking any medicine? Specify:		
2. Are you presently under the care of a physician?		
3. Have you had radiation treatments or chemotherapy?		
4. When was your last dental exam?		
5. When was your last dental x-ray taken?		
6. Have you ever had pain in your jaw joint(s) or near your ears?		
7. Does your jaw make noise during opening or closing?		
8. Has your jaw ever locked open or closed?		
9. Does your jaw feel comfortable in your present bite?		
10. Have you ever had an injury to your face or jaw?		
11. Have you ever had a "whiplash" accident?		
12. If your jaw joint(s) do bother you, how long ago did it start?		
13. Do you habitually clench or grind your teeth during the night or day?		

Date: _____ Parent/Guardian Signature _____