PINE ORTHODONTICS
CHOOSE US and Smile

205 East Beaver Ave. • State College, PA 16801 • 814-237-1751
220 North Front St. • Philipsburg, PA 16866 • 814-343-5711
200 Hospital Dr., Suite 4 • Tyrone, PA 16686 • 814-684-5368

1-855-32-ORTHO
smiles@pineortho.com
www.pineortho.com

Welcome! *Our specialty is creating smiles for life. Please provide an answer for each question listed. If the question doesn't apply to you please write/type N/A in the field.*

PATIENT INFORMATION — ADULT

ALL ABOUT YOU

Name:_____
I prefer to be called:_____ (LAST / FIRST / MI / MR MRS MS DR)
Male ☐ Female ☐ Birthdate:_____/_____/_____ Age:
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐
SS#: _____
Home Address:_____
City: _____ State: _____ Zip:_____
Cell #: _____ Home #: _____ Email: _____
Occupation:_____ Employer/School:_____ How Long?:_____
Work #:_____ Ext:_____ Work Address: _____
City: _____ State: _____ Zip:_____
Where/when is the best time to reach you?:_____
Whom may we thank for referring you?: _____

EMERGENCY CONTACT INFORMATION

His/Her Name: _____ Relation: _____
Phone: _____ Ext: _____

DENTAL HISTORY

General Dentist: _____ Date of Last Exam: _____
What are the main concerns that you would like orthodontics to accomplish? _____
_____
Have you ever had or been evaluated for orthodontic treatment:? Yes ☐ No ☐ If yes by whom? _____ City & State_____
Have you ever had a serious/difficult problem with any previous dental work? Yes ☐ No ☐
Your current dental health is: Good ☐ Fair ☐ Poor ☐
Do you like your smile? Yes ☐ No ☐
Do your gums ever bleed? Yes ☐ No ☐
Have you ever had an injury to your: Mouth ☐ Teeth ☐ Chin ☐
Do you have any missing or extra permanent teeth? Yes ☐ No ☐
Do you generally breathe through your mouth? Yes ☐ No ☐ If yes: While awake ☐ While asleep ☐
Do you have or ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? Yes ☐ No ☐
Painful chewing? Yes ☐ No ☐
Do you clench your teeth? Yes ☐ No ☐
Do you grind your teeth? Yes ☐ No ☐
Headaches? Yes ☐ No ☐
Clicking or popping jaw? Yes ☐ No ☐
Are teeth sensitivite to temperature or pressure Yes ☐ No ☐

MEDICAL HISTORY

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

Are you currently under the care of a physician? Yes ☐ No ☐
Please explain: _____

Are antibiotics necessary prior to treatment? Yes ☐ No ☐

Are you taking a prescription/over-the-counter drugs? Yes ☐ No ☐
Please list each one: _____

_____

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

Abnormal Bleeding	☐ Yes	☐ No	Muscular Disorder	☐ Yes	☐ No	Hospitalization	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Nervous Disorder	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Artificial Bones/Joints/Valves	☐ Yes	☐ No	Drug/Alcohol Abuse	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Epilepsy/Seizures/Fainting	☐ Yes	☐ No	Psychiatric/Emotional Problems	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
Bone Disorders	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Heart Surgery/Pacemaker	☐ Yes	☐ No	Severe/Frequent Headaches	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Ulcers/Colitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No	High/Low Blood Pressure	☐ Yes	☐ No	***Are you Pregnant***	☐ ***Yes***	☐ ***No***
Glaucoma	☐ Yes	☐ No	HIV+/AIDS	☐ Yes	☐ No			

Please list any serious medical condition(s) that you have ever had: _____

_____

_____

Are you allergic to any of the following?

Aspirin	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Dental Anesthetics	☐ Yes	☐ No	Metals/Plastics	☐ Yes	☐ No	Other	☐ Yes	☐ No

Please list any other drugs/materials that you are allergic to: _____

_____

_____

SIGNED CONSENT

I hereby authorize Dr. Pine and his professional team to perform an orthodontic evaluation and consent to the taking of xray films, photographs, and other records (if necessary) to determine appropriate orthodontic treatment on the above-named patient.

I also authorize Dr. Pine's team to leave messages about appointments on my voice mail or answering machine, and agree to receive email reminders and text messages about appointments.

I understand where appropriate , credit bureau reports may be obtained.

Typed Name/Signature:_____ Relationship to Patient:_____ Date: _____