# ORTHODONTIC SPECIALISTS OF OHIO

James A. Tetz DMD, Inc

## ORTHODONTIC PATIENT INFORMATION

First Name_____Middle_____Last_____Nickname_____

Patient Address_____
City Zip

Patient Home Phone_____

Patient's Date of Birth_____Age_____Gender_____

Patient's Dentist_____ Date of last visit_____ City of Dentist: _____

Referred by_____ Patient's physician_____ City of Physician_____

Please explain reasons for seeking orthodontic care_____

School_____Grade/Year_____

Patient's interest and hobbies_____

**IF THE PATIENT IS A MINOR, PLEASE COMPLETE PARENT/GUARDIAN INFO:**

Patient lives with (parents, mother, father, guardian, etc…) _____

***Mother/Step-mother/(circle) Name**_____

Address if different from patient_____

Cell_____Email Address_____

Work place_____ Occupation_____

***Father/Step-father/(circle) Name**_____

Address if different from patient_____

Cell_____Email Address_____

Work place_____Occupation_____

***Guardian or other step-parent/ (circle) Name**_____

Address if different from patient_____

Cell_____Email Address_____

Work place_____ Occupation_____

***Is there a custodial parent by court order? If yes, Name**_____

Relationship to patient_____

**IF THE PATIENT IS AN ADULT:**

Cell_____Email Address_____

Workplace_____ Occupation_____

**QUESTIONS FOR ALL PATIENTS:**

Does anyone in the family have a similar problem? ☐Yes ☐No Describe_____



TetzOrthodontics.com DrJamesTetz@gmail.com

2100 East High Street - Suite 105 Springfield, Ohio 45505 Telephone: (937) 324-5700
66 A West High Street London, Ohio 43140 Telephone: (740) 852-5050

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Patient Name_____Date_____

## JAW JOINT (TMJ) HISTORY

1. Does the patient now have, or has the patient ever had **pain** in the jaw joints or the area of the jaw joints?..... ☐Yes ☐No
2. Does the patient now have, or has the patient ever had pain when **chewing**?.... ☐Yes ☐No
3. Does the patient now have, or has the patient ever had pain when **yawning**?... ☐Yes ☐No
4. Does the patient now have, or has the patient ever had pain when **opening**?..... ☐Yes ☐No
5. Does the patient now have, or has the patient ever had **noise** in the jaw joints?..... ☐Yes ☐No
6. Does the patient now have, or has the patient ever had a **click** in the jaw joints?..... ☐Yes ☐No
7. Does the patient now have, or has the patient ever had a **pop** in the jaw joints?..... ☐Yes ☐No
8. Does the patient now have, or has the patient ever had **difficulty** opening their mouth? ……. ☐Yes ☐No
9. Does the patient now have, or has the patient ever had the jaw become **"stuck"** or **"locked"**?..... ☐Yes ☐No
10. Does the patient **grind** their teeth?..... ☐Yes ☐No

## DENTAL HISTORY

1. Does the patient now have, or has the patient ever had any problem with:
   - Sensitive, Sore, or **Bleeding gums** (gingiva)?..... . ☐Yes ☐No
   - **Bone loss** around the teeth? ……... ☐Yes ☐No
   - **Recession** of the gum (gingival)?..... . ☐Yes ☐No
2. Has the patient ever lost or had **teeth removed**?..... ☐Yes ☐No

Please give teeth and reason:_____

_____

3. **Does** the patient now have a **finger or thumb sucking habit**? …….. ☐Yes ☐No
4. **Did** the patient have a finger or thumb sucking habit? To what age?_____ ..... ☐Yes ☐No

Please circle any **other habits:** Nail biting, lip biting or sucking, mouth breathing, tongue thrusting, teeth clenching, teeth grinding, pencil biting

**Other:**

5. Does the patient now have, or has the patient ever had difficulty in **swallowing** or **chewing** foods? …….. ☐Yes ☐No
6. Does the patient now have, or has the patient ever had any **speech** problems or speech therapy?..... ☐Yes ☐No

Please describe:_____

_____

7. Does the patient have any **Other** special medical, jaw joint, or dental problems that have not been mentioned above?..... ☐Yes ☐No

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## MEDICAL HISTORY

Patient Name_____Date_____

Patient's Physician_____City_____

1. Is the patient taking any medication now?..... ☐Yes ☐No
Please list the medications and the purpose of the medication:

_____

2. Does the patient have allergies to medications or anything else?..... ☐Yes ☐No
Please list the allergic items:_____
3. Has the patient ever had any hospitalizations, operations, or major illnesses?..... ☐Yes ☐No
Please date and describe:

_____

4. Does the patient now have, or has the patient ever had frequent headaches?..... ☐Yes ☐No
Please date and describe:

_____

5. Has the patient had any injuries to the face, mouth, teeth or jaws?..... ☐Yes ☐No
Please date and describe:

_____

6. For women: Are you pregnant?..... ☐Yes ☐No

7. Does the patient now have, or has the patient ever had artificial joints placed?..... ☐Yes ☐No

8. Does the patient now have, or has the patient ever had rheumatic fever or rheumatic heart disease?... … ☐Yes ☐No

9. Does the patient now have, or has the patient ever had any heart problems?..... ☐Yes ☐No

10. Does the patient now have, or has the patient ever had a heart murmur?..... ☐Yes ☐No

11. Does the patient now have, or has the patient ever had Tuberculosis? …… ☐Yes ☐No

12. Does the patient now have, or has the patient ever lived with someone that had Tuberculosis? ……... ☐Yes ☐No

13. Has the patient ever had any problems with the healing of broken bones? …… ☐Yes ☐No

14. Does the patient now have, or has the patient ever had ear, nose, throat, or sinus problems? ……... ☐Yes ☐No

Please date and describe:_____

15. Has the patient had tonsils or adenoids removed? When? _____.....…… ☐Yes ☐No

16. Does the patient now have, or has the patient ever had tubes in the ears? …… ☐Yes ☐No

17. Does the patient now have snoring at night?..... ☐Yes ☐No

18. Is the patient now, or has the patient ever been a mouth breather? (difficulty breathing through the nose)?

…….. ☐Yes ☐No

19. Are the patient's lips apart often? …… ☐Yes ☐No

20. Does the patient currently, or has the patient in the past, use any tobacco products?..... ☐Yes ☐No
(cigarettes, snuff, cigars, chewing tobacco, or pipe) Please state the items: _____

_____

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## RESPONSIBLE PARTY INFORMATION

**Responsible Party #1**

Self_____Spouse_____Mother_____Father_____Other_____

Name_____Phone (  ) _____

Address_____

Employer_____Social Security Number_____

Driver's License #_____Date of Birth_____

**Responsible Party #2**

Self_____Spouse_____Mother_____Father_____Other_____

Name_____Phone (  ) _____

Address_____

Employer_____Social Security Number_____

Driver's License #_____ Date of Birth_____

**Required for billing purposes**There cannot be financial arrangements if no SS is provided**



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## INSURANCE INFORMATION

**INSURANCE #1**

Is there orthodontic insurance? ☐ YES ☐ NO

Insurance Company Name: _____

Company Address: _____Company Phone number:_____

ID Number:_____ Group Number:_____

Subscriber's name:_____ Subscriber's Date of Birth:_____

Subscriber's Social Security Number:_____

What is the Lifetime Maximum Amount for Orthodontics? _____

IF THE INFORMATION REQUIRED FOR INSURANCE SUBMISSION IS NOT PROVIDED, YOU ARE RESPONSIBLE FOR THE FULL FEE. NO INSURANCE BENEFITS CAN BE USED.

**INSURANCE #2**

Is there orthodontic insurance? ☐ YES ☐ NO

Insurance Company Name: _____

Company Address: _____Company Phone number:_____

ID Number:_____ Group Number:_____

Subscriber's name:_____ Subscriber's Date of Birth:_____

Subscriber's Social Security Number:_____

What is the Lifetime Maximum Amount for Orthodontics? _____

***THERE IS A 90 DAY SERVICE WINDOW FOR NEW INSURANCE***

***Required information to submit insurance***

**Due to HIPPA laws we are unable to accept personal information via text or email**



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