Nettune and Banasiak Orthodontic Associates, P.A.

Roger C. Nettune, D.M.D., M.S.
Kenneth Banasiak, D.M.D.
Orthodontic Specialty License Number 2849, 5542

Basking Ridge Office:
65 South Maple Avenue
Basking Ridge, N.J. 07920
Phone: **(908) 766-2444**

Mendham Office:
18 East Main St., PO Box 500
Mendham, N.J. 07945
Phone: **(973) 543-6644**

Bedminster Office:
85 Somerville Rd.
Bedminster, N.J. 07921
Phone: **(908) 781-0800**

Youth Patient History Form

Patient Number____________________

Patient's Name____________________ (First / Middle / Last) Nickname ________ Sex _____ Age_____ Birthdate____ /___ /____

Patient's Address ____________________ Home Phone ________ Parent Cell Phone ________

School ____________________ Parent E-mail ____________ Grade ______

Hobbies/Interests ____________________

Father's Name ________________ Home Phone ____________ Marital Status ________

Father's Address ____________________

His Employer ________________ Business Phone ____________ OK to call at work? ☐Y ☐N

Mother's Name ________________ Home Phone ____________ Marital Status ________

Mother's Address____________________

Her Employer ________________ Business Phone ____________ OK to call at work? ☐Y ☐N

Responsible Party's Name ________________ Home Phone ____________

His/Her Address________________ Relationship____________

Do you have orthodontic dental insurance? ☐ Y ☐ N Group ____________ Group #____________

Insurer's Address ________________ Referral Source ____________

Any family member in TX or treated here? ☐ Y ☐ N Name(s) ____________( ) ____________ ( ) ____________( )

Your chief concern(s): ____________________

Dental History

Patient's D.D.S. ________________ General Health __________ Last visit to D.D.S. Mos. ______

D.D.S.'s Address________________ Phone ____________

Previous Orthodontic TX? ☐ Y ☐ N Length of TX ________ Mos. Parents had Orthodontic TX? ☐ Y ☐ N Mother ☐ Father ☐

Orthodontist's Name________________ Address ________________

Oral Habits ____________ Breathing Problems ____________ Speech & Other Problems ____________

Occlusion

Are you aware of pain in the TMJ? ☐ Y ☐ N
Are you aware of popping or clicking? ☐ Y ☐ N
Do you suffer from frequent headaches? ☐ Y ☐ N
Do you grind or clench your teeth? ☐ Y ☐ N
Are you aware of tightness of joints in the morning? ☐ Y ☐ N
Do you have pain or soreness in the eyes? ☐ Y ☐ N
Do your jaws get tired during a meal? ☐ Y ☐ N
Do you have difficulty swallowing? ☐ Y ☐ N
Do you ever have neck or shoulder pain? ☐ Y ☐ N
Other________________

Medical History

Patient M.D. ____________________

M.D.'s Address ________________ Phone ____________

Operations: Tonsils Removed ☐ Y ☐ N; Adenoids Removed ☐ Y ☐ N; Other ________

Serious Illness: Heart Trouble ☐ Y ☐ N; Hepatitis ☐ Y ☐ N; Diabetes ☐ Y ☐ N; Epilepsy ☐ Y ☐ N; Kidney/Liver Involvement ☐ Y ☐ N; Gland or Bleeding Disorder ☐ Y ☐ N; Childhood ☐ Y ☐ N; HIV Positive ☐ Y ☐ N; Rheumatic Fever ☐ Y ☐ N

Presently under medical care? ☐ Y ☐ N For what? ____________ Your height ______ weight______

Presently taking medication? ☐ Y ☐ N What Medicine ____________ Do you wear contacts ☐ Y ☐ N

Have you ever taken bisphosphonates? ☐ Y ☐ N

Do you have any drug reactions? ____________ Allergies? ____________

Comments on medical history________________

I, the undersigned, have given the above dental and medical information. I have reviewed it, and find it accurate. If there are any later changes to this history record, I will so inform this practice.

Signature of adult patient/parent ________________ Date ________

The above information has been reviewed with the above named individual.

Signature of interviewer ________________ Date ________

Communications Coordinator To Nettune and Banasiak Orthodontic Associates, P.A.