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**

Adult Patient History Form

Patient Number__________

Patient's Name__________ (First Middle Last) Nickname _____ Sex ____ Age____ Birthdate____ /____ /____

Patient's Address __________ Home Phone _____ Cell Phone _____

Hobbies/Interests __________ E-mail__________

Patient's Employer __________ Business Phone _____ OK to call at work? ☐Y ☐N

Employer's Address__________

Spouse's Name __________

Spouse's Employer __________ Business Phone _____ OK to call at work? ☐Y ☐N

Employer's Address__________

Responsible Party's Name __________ Relationship to Patient _____ Home Phone _____

Responsible Party's Address__________ Business Phone _____

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.