ROBERT L. KASPERS, DDS., MS.

practice limited to orthodontics

Welcome to our office! Today's visit involves taking photographs and a dental CBCT scan to give Dr. Kaspers a general idea as to what type of malocclusion or dental problem exists.

For a more detailed diagnosis, a separate records appointment may be necessary. These records may be used by the doctor in scientific papers or demonstrations.

When all records have been obtained, a formal consultation will be arranged. At that time, the necessary treatment plan and any questions you may have will be thoroughly discussed.

PLEASE COMPLETE THE FOLLOWING: (Please Print!) Date: _____

PATIENT:

Name: _____

Birthdate: _____ Age: _____ Sex: F M

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Occupation: _____

Employer: _____

Employer's Address: _____

_____

Business Phone: _____

Emergency Contact Name and Number: _____

Dentist: _____ Referred By: _____

When was your last dental visit? _____

Are you covered by dental insurance? ☐ Yes - Company Name _____ ☐ No

Are you covered by medical insurance? ☐ Yes - Company Name _____ ☐ No

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ S. S. # _____

☐ Patient ☐ Spouse ☐ Other _____

SIGNATURE: _____

Name: _____

MEDICAL HISTORY

Are you in good health? _____ Yes ☐ No ☐

Do you have any history of major illness? _____ Yes ☐ No ☐

Have you ever been under the care of a physician for illness? _____ Yes ☐ No ☐

Please list: _____

Check any of the following for which you have been treated:

Diabetes _____ ☐	Tuberculosis _____ ☐	Endocrine Problems _____ ☐
Pneumonia _____ ☐	Anemia _____ ☐	Prolonged Bleeding _____ ☐
Heart Trouble _____ ☐	Epilepsy _____ ☐	Fainting Or Dizziness _____ ☐
Rheumatic Fever _____ ☐	Asthma _____ ☐	Nervous Disorders _____ ☐
Bone Disorders _____ ☐	Kidney Involvement _____ ☐	Liver Involvement _____ ☐

Do you have a tendency to colds? ☐ Sore throats? ☐ Ear infections? ☐

Have tonsils and adenoids been removed? What age? _____ Yes ☐ No ☐

List any drugs or medications now being taken, give reasons: _____

_____

List any allergies or drug sensitivities: _____

Height _____ Weight _____

DENTAL HISTORY

Have you had any injuries to the face, mouth or teeth? _____ Yes ☐ No ☐

Have you ever sucked a thumb or fingers? Until what age? _____ Yes ☐ No ☐

Do you have any speech problems? _____ Yes ☐ No ☐

Are you a mouth breather? While awake? _____ Yes ☐ No ☐

While asleep? _____ Yes ☐ No ☐

Have you been informed of any missing or extra permanent teeth? _____ Yes ☐ No ☐

Has an orthodontist been consulted previously? _____ Yes ☐ No ☐

Have you had previous orthodontic treatment? _____ Yes ☐ No ☐

OCCLUSION DATA

Are you aware of pain in the T.M.J.? _____ Yes ☐ No ☐

Are you aware of popping or clicking? _____ Yes ☐ No ☐

Do you suffer from headaches? _____ Yes ☐ No ☐

Do you ever take aspirin? If yes, for what reason? _____ Yes ☐ No ☐

Are you aware of grinding or clenching your teeth? _____ Yes ☐ No ☐

Are you aware of tightness of joints in the morning? _____ Yes ☐ No ☐

Do your jaws get tired during a meal? _____ Yes ☐ No ☐

Do you have difficulty swallowing? _____ Yes ☐ No ☐

Do you ever have any neck or shoulder pain? _____ Yes ☐ No ☐

Reasons For Consultation _____

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

Signature _____ Date _____

This information has been reviewed with the above named individual.

Signature _____ Date _____

POSITION