ROBERT L. KASPERS, DDS., MS.

practice limited to orthodontics

Welcome to our office! Today's visit involves an initial examination 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 will be scheduled. The records consist of a dental CT scan, photographs and plaster models of the teeth. 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 this 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: ________

Occupation: ______________________________

Employer: ______________________________

Employer's Address: ______________________________

____

Business Phone: ________ Home Phone: ________

Emergency Contact Name: ______________________________

Emergency Contact Number: ______________________________

Patient's Cell Phone: ______________________________

IF APPLICABLE:

Mom, Cell Phone: ______________________________

Dad, Cell Phone: ______________________________

PARENTS: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

(If guardian, please fill in your background information under mother or father.)

FATHER:

Name: ______________________________

Home Address: ______________________________

City: ________ State: ________ Zip: ________

Occupation: ______________________________

Employer: ______________________________

Employer's Address: ______________________________

____

Business Phone: ________ Home Phone: ________

MOTHER:

Name: ______________________________

Home Address: ______________________________

City: ________ State: ________ Zip: ________

Occupation: ______________________________

Employer: ______________________________

Employer's Address: ______________________________

____

Business Phone: ________ Home Phone: ________

Siblings In Family: ________ ( ) ________ ( ) ________ ( ) ________ ( ) ________ ( )
NAME AGE NAME AGE NAME AGE NAME AGE NAME AGE

Have any children had orthodontic treatment? ______________________________

Child's Name: ______________________________ Orthodontist: ______________________________

Family Dentist: ______________________________ Referred By: ______________________________

When was the patient's last dental visit? ______________________________ months

Are you covered by insurance for orthodontic treatment? Yes ________ No ________

If so, please give the name of the company: ______________________________

PERSON RESPONSIBLE FOR THIS ACCOUNT: ______________________________ S.S.# ______________

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ______________

SIGNATURE: ______________________________

Name: ____________________

MEDICAL HISTORY

Is patient in good health? ____________________ Yes ☐ No ☐

Does patient have any history of major illness? ____________________ Yes ☐ No ☐

Has the patient ever been under the care of a physician for illness? ____________________ Yes ☐ No ☐

Please list: ____________________

Check any of the following for which the patient has 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 ☐

Does patient have 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 sensitivity: ____________________

Has the patient reached puberty? Girls — Has she started menstruation? Yes ☐ No ☐

Boys — Has his voice changed? Yes ☐ No ☐

Height ____________ Weight ____________

DENTAL HISTORY

Has there been any injuries to the face, mouth or teeth? ____________________ Yes ☐ No ☐

Has the patient ever sucked a thumb or fingers? Until what age? ____________________ Yes ☐ No ☐

Does the patient have any speech problems? ____________________ Yes ☐ No ☐

Is the patient 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 ☐

Has the patient had previous orthodontic treatment? ____________________ Yes ☐ No ☐

Has either parent had 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 ☐

Reason 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 so inform this practice.

Signature (Patient/Responsible Adult) ____________________ Date ____________

This information has been reviewed with the above named individual.

Signature ____________________ Date ____________

POSITION