Piekarsky
ORTHODONTICS
for children & adults

Lawrence Piekarsky, DMD, CAGS
NJ Spec Permit #3571

Date:______________

Patient's Full Name: ________________________________ Prefers to be called: ____________

Patient's Address: ____

____

Home Phone: ________________________ Cell Phone: ____________________________

Patient's Email Address: ____

Patient's Birthday: ___________________________ Age: _____ SSN: ________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced

Patient's Dentist: ____________________________ Date of Last Visit_____________________

Dentist's Address & Phone____

Whom may we thank for referring you? ____

Names and ages of children: ____

Other family members seen by us:____

Your Employer: ____

Occupation: ________________________________ Work phone: ______________________

Spouse's Name: ____________________________ Spouse's birthday: _____________________

Spouse's Cell phone: _________________________ Spouse's Work phone: __________________

Spouse's Employer: __________________________ Occupation: __________________________

Emergency Contact and Phone (if different than spouse): __________________________________

Primary Dental Insurance Information

Insured's Name: ______________________________ Insured's SSN: ____________________

Insured's Employer: ____________________________ Insured's Birthday: __________________

Employer Address: ____

____

Insurance Company Name: ____

Insurance Company Address: ____

____

Group Number (Plan, local or policy No): ____

150 Hinchman Ave, Suite 1
Wayne, NJ 07470-2360
{973} 942.0900

5677 Berkshire Valley Rd
Oak Ridge, NJ 07438
{973} 545.2391

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AAO Member American Association of Orthodontists

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Health History

Medical History

(please check if patient has, or has had...)

- ◻ AIDS/HIV Infection
- ◻ Alcoholism
- ◻ Angina/Chest Pain
- ◻ Arthritis
- ◻ Asthma/Breathing Problems
- ◻ Blood Disease
- ◻ Cancer/Tumors
- ◻ Cold Sores
- ◻ Diabetes
- ◻ Drug Addiction/Use
- ◻ Emotional Problems
- ◻ Endocrine Problems
- ◻ Epilepsy
- ◻ Excessive Bleeding
- ◻ Heart Problems
- ◻ Hepatitis A, B or C
- ◻ High/Low Blood Pressure
- ◻ Intestinal Problems
- ◻ Joint Swelling
- ◻ Kidney Problems
- ◻ Liver Problems
- ◻ Lung Disease
- ◻ Rheumatic Fever
- ◻ Thyroid Problems
- ◻ Tonsils Removed
- ◻ Tuberculosis

Please explain all checked responses:

____

List any allergies:

____

List any medications:

____

Dental History

(please check if patient has, or has had...)

- ◻ Any injuries to face, mouth or teeth?
- ◻ Thumb, finger or lip sucking habit?
  - ◻ continuing ◻ discontinued
- ◻ Mouth breathing when asleep, awake?
- ◻ Any known missing permanent teeth?
- ◻ Any known extra permanent teeth?
- ◻ Any teeth removed by extraction?
  - When? __________________
- ◻ Is there a tongue thrust problem?
- ◻ Any clenching/grinding of teeth?
  - ◻ Day ◻ Night ◻ Bot
- ◻ Frequent Headaches?
- ◻ Any pain, popping or locking on opening or closing jaw movement?
- ◻ Any muscle tenderness or stiffness in jaw or neck area?
- ◻ Any ringing in ear or dizziness?
- ◻ Any previous treatment of TMJ problems?

Please explain all checked responses:

____

Please list your chief concern(s) and what you would like treatment to accomplish:

____
____
____

Have you ever been ◻ evaluated or ◻ treated by any previous orthodontist? If yes, complete below.

Orthodontist: ______________________________ Date last seen: _________________________

Address:____

Type of treatment: ____

SIGNATURE: ____ **Date:** _________________

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