SABAT ORTHODONTICS
Creating Confident Smiles for Your Future

Michael R. Sabat, D.D.S., M.S., INC.
Diplomate of the American Board of Orthodontics

Parma Ridge Medical Center
6789 Ridge Road #308
Parma, OH 44129
440-845-3360

Brecksville Professional Building
8865 Brecksville Road
Brecksville, OH 44141
440-526-0175

Date: _____

Confidential Patient Information for Adult patients

Please provide us with the following information:

Patient's Last Name: _____ First: _____ Middle Initial: _____

I prefer to be called: _____ Sex: Male ☐ Female ☐ Birth Date: ____/ ____/ ____ Age: ____

Patient is: Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Name of Spouse/Relative: _____ Relationship to you: _____ Phone: _____

Patient's Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____

May we e-mail appointment confirmations? Yes ☐ No ☐ Or do you prefer a text message: Yes ☐ No ☐

Employer: _____ Occupation: _____ Work Phone: _____

OK to contact you at work? Yes ☐ No ☐

Do you have insurance that covers orthodontic treatment? Yes ☐ No ☐ Unsure ☐

Insured Name: _____ ID or Soc Sec #: _____ Birth date: ___/ ___/ ___

Employer Name: _____ Insurance Co.: _____ Phone: _____

Secondary Insurance:

Insured Name: _____ ID or Soc Sec #: _____ Birth date: ___/ ___/ ___

Employer Name: _____ Insurance Co.: _____ Phone: _____

Who is financially responsible for this account?

Patient ☐ Spouse ☐ Parents ☐ Other ☐ please specify: _____

Last Name: _____ First: _____ Phone: _____

Address (if different than patient): _____ City: _____

State: ____ Zip Code: _____

Who suggested that you might need orthodontic treatment? _____

Whom may we thank for referring you to our office? _____

Why did you select our office? _____

Reason for consultation: _____

Have we treated any of your relatives or friends? Yes ☐ No ☐ If YES, whom? _____

Health History: For the following questions mark yes or no. The answer are for our records and will be kept confidential.

Name of Patient's Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of last visit: _____ Reason: _____

History of:		Specifics of problem if *YES:*	Please explain…indicate any medication & dosage
Head/Neck Problems?	NO ☐ YES ☐	Headaches: Migraine ☐ Sinus ☐ Eyes ☐ Temples ☐ Back of head ☐ Painful scalp ☐ Neck pain ☐ Lumps in neck ☐ Tired/Sore neck muscles ☐	_____ _____ _____
Neural Problems?	NO ☐ YES ☐	Epilepsy ☐ Seizures ☐ Numbness/Tingling ☐	_____
Ear Problems	NO ☐ YES ☐	Pain ☐ Clogged ☐ Hissing ☐ Ringing ☐ Dizziness ☐ Nausea ☐ Loss of hearing volume ☐ Loss of balance ☐	_____ _____
Nose/Sinus Problems?	NO ☐ YES ☐	Obstruction ☐ Stuffiness ☐ Runny nose ☐	_____
Throat Problems?	NO ☐ YES ☐	Sore throat ☐ Swallowing difficulties ☐ Lump in throat ☐ Laryngitis ☐ Persistent Cough/Clearing throat ☐	_____ _____ _____
Breathing Problems?	NO ☐ YES ☐	Asthma ☐ Wheezing ☐ Shortness of breath ☐ Chronic cough ☐ Cough up blood/sputum ☐ Snoring ☐ Sleep apnea ☐ Mouth breather ☐	_____ _____ _____
Bone Problems?	NO ☐ YES ☐	Break easily ☐ Pain ☐ Arthritis ☐ Joint pain ☐ Joint swelling ☐	_____ _____
Heart Problems?	NO ☐ YES ☐	Congenital heart disease ☐ Heart valve disease ☐ High blood pressure ☐ Low blood pressure ☐ Heart murmur ☐ Mitral valve prolapse ☐	_____ _____ _____
Blood Problems?	NO ☐ YES ☐	Hemophilia ☐ Anemia ☐ Bruise easily ☐ Bleed easily ☐ Blood clots ☐ Had stroke ☐	_____ _____
Chronic Disease Problems?	NO ☐ YES ☐	Diabetes ☐ Cancer ☐ Hepatitis A ☐ B ☐ HIV ☐ Tuberculosis ☐ Infectious disease ☐ AIDS ☐ Swelling ☐ Tonsillitis ☐ Excessive colds ☐	_____ _____ _____
One Time Problems?	NO ☐ YES ☐	Measles ☐ Mumps ☐ Chicken Pox ☐ Rheumatic fever ☐	_____ _____
Heart Surgery?	NO ☐ YES ☐	Heart valve (date _____) Pacemaker (date _____) Bypass (date _____)	_____ _____
Other Surgery?	NO ☐ YES ☐	Tonsils (date _____) Adenoids (date _____) Other (date_____) specify _____	_____ _____
Serious Injury?	NO ☐ YES ☐	Broken bones (date _____) _____	_____
Psychological Problems?	NO ☐ YES ☐	Anxiety ☐ Depression ☐ Insomnia ☐ Psychiatric Disorder ☐	_____ _____
Habit Excesses?	NO ☐ YES ☐	Smoking ☐ Caffeine ☐ Alcohol ☐	_____
Presently taking Medications?	NO ☐ YES ☐	Birth control ☐ Blood pressure ☐ Diuretics ☐ Insulin ☐ Blood thinner ☐ Heart ☐ Tranquilizers ☐ Anticonvulsant ☐	_____ _____
Allergic Reactions?	NO ☐ YES ☐	Latex ☐ Nickel ☐ Metals/Plastics ☐ Medication ☐ Seasonal ☐ Foods ☐	_____ _____
Anesthetic Reaction?	NO ☐ YES ☐	Local anesthetic ☐ General anesthetic ☐	_____

Are there any other medical conditions that we should be aware of? _____

Women Only: Are you pregnant? **NO □ YES □ DK/U □**

Family History of:		*If YES, which family member? (Parents or siblings only)*
Diabetes?	**NO □ YES □**	_____
Cancer or skin cancer?	**NO □ YES □**	_____
Infectious disease?	**NO □ YES □**	_____
Heart disease?	**NO □ YES □**	_____
High blood pressure?	**NO □ YES □**	_____
Lung disease?	**NO □ YES □**	_____
Unusual dental problems?	**NO □ YES □**	_____

Dental History:

Name of Patient's Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of last visit: _____ Reason: _____

History of:

NO □ YES □ Any teeth removed: permanent **or e**xtra (supernumerary) Right side □ Left side □ Upper □ Lower □

NO □ YES □ Any missing teeth: (congenitally missing teeth) Right side □ Left side □ Upper □ Lower □

NO □ YES □ Chipped or injured permanent teeth Right side □ Left side □ Upper □ Lower □

NO □ YES □ Are you aware of any loose, broken or missing fillings Right side □ Left side □ Upper □ Lower □

NO □ YES □ Any teeth irritating cheeks, lips tongue or palate Right side □ Left side □ Upper □ Lower □

NO □ YES □ Areas of food impaction Right side □ Left side □ Upper □ Lower □

NO □ YES □ **S**ensitivity to: hot □ cold □ sweets □ chewing □ Right side □ Left side □ Upper □ Lower □

NO □ YES □ Any concerns about spacing, crooked or protruding teeth

NO □ YES □ Thumb or Finger Sucking □ Tongue Thrusting □ Nail Biting □ Lip Biting □

NO □ YES □ History of speech problems

NO □ YES □ Mouth breathing habit, snoring or breathing difficulties

NO □ YES □ Grinding or clenching teeth During the day □ When sleeping □

NO □ YES □ Have you ever been treated for "TMJ" or "TMD" problems

NO □ YES □ Pain or soreness in facial muscles or around the ears

NO □ YES □ Difficulty chewing or opening

NO □ YES □ Jaw joint pain/noise/locking Right side □ Constant □ Periodic □ When you: Chew □ Yawn □ Talk □ Open wide □
Left side □ Constant □ Periodic □ When you: Chew □ Yawn □ Talk □ Open wide □

NO □ YES □ Jaw fractures/Cysts Right side □ Left side □ Upper □ Lower □

NO □ YES □ Frequent canker sores or cold sores

NO □ YES □ Bleeding gums, bad taste or mouth odor

NO □ YES □ Any serious trouble associated with previous dental treatment

NO □ YES □ Are you being treated by another dentist Name: _____

How often do you brush? _____ Floss? _____

Orthodontic Concerns

What are the orthodontic concerns of patient?

_____

What are the orthodontic concerns of your dentist?

_____ _____

Have you had a prior orthodontic examination **NO ☐ YES ☐** by: _____

Have you ever had:			**Doctor:**
Periodontal (gum) Treatment?	**NO ☐ YES ☐**	What Kind of treatment? _____	_____
Orthodontic (braces) Treatment?	**NO ☐ YES ☐**	What Kind of treatment? _____	_____
Endodontic (root canal) Treatment?	**NO ☐ YES ☐**	What Kind of treatment? _____	_____
Oral Surgery?	**NO ☐ YES ☐**	What Kind of treatment? _____	_____

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time. If there are any future changes sin this information, I will inform this practice of these changes. I also understand that my diagnostic records may be used for educational and promotional purposes.

_____ _____ _____ _____
Signature of person filling out this health history **Date** **Signature of T. C. who reviewed this health history** **Date**

_____ _____
Signature of Doctor who reviewed this history **Date**

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)