SABAT ORTHODONTICS
Creating Confident Smiles for Your Future

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

Michael R. Sabat, D.D.S., M.S., INC.

Date: _____ **Confidential Patient Information for patients under 18 years of age**

Please provide us with the following information on patient

Patient's Last Name: _____ First: _____ Middle Initial: _____ I prefer to be called: _____

Sex: Male ☐ Female ☐ Birth Date: ____/ ____/ ____ Age: ____

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

Home Phone: _____ Patient Cell Phone: _____ School: _____ Grade: _____

Musical instruments played: _____ Sports and/or Hobbies: _____

First & Last Name, Birthdate of siblings: _____ ____/ ____/ ____ M/F _____ ____/ ____/ ____ M/F

_____ ____/ ____/ ____ M/F _____ ____/ ____/ ____ M/F

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

Who suggested that your child might need orthodontic treatment? _____

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

Why did you select our office? _____Reason for consultation: _____

Please provide us with the following information for responsible party & insurance

Father: _____ Marital status: _____Home Phone: _____ Cell Phone: _____

Residence::_____City: _____State: ____ Zip : _____ Circle one: OWN – RENT

Previous Address (less than 3 yrs_____City_____State_____Zip_____

Address (if different than patient's) _____City_____State_____Zip_____

E-mail address: _____ May we e-mail appointment confirmations? Yes ☐ No ☐ or do you prefer a text message: Yes ☐ No ☐

Employer: _____Work Phone: _____ No. Years Employed_____

Does father have insurance that covers orthodontic treatment? Yes ☐ No ☐ Unsure ☐

Insurance Co.: _____ _Address: _____

Phone: _____ _____ ID or Soc Sec #: _____ ___Birth Date:_____ Group#_____

Mother: _____ Marital status: _____Home Phone: _____ Cell Phone: _____

Address (if different than patient's):_____ City: _____ State: ____ Zip Code: _____

E-mail address: _____ May we e-mail appointment confirmations? Yes ☐ No ☐ or do you prefer a text message: Yes ☐ No ☐

Employer: _____ Work Phone: _____ No. Years Employed_____

Does mother have insurance that covers orthodontic treatment? Yes ☐ No ☐ Unsure ☐

Insurance Co.: _____ Address: _____

Phone: _____ _____ ID or Soc Sec #: _____ ___Birth Date:_____ Group#_____

Who is financially responsible for this account? Parents □ Father □ Mother □ Other □ please specify: _____

Last Name: _____ ____First: _____ Phone: _____

Address (if different than patient's):_____ City: _____ State: ____ Zip Code: _____

If divorced or separated, who is the custodial parent? Mother □ Father □ Shared □

Health History: For the following questions mark yes or no. The answers 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 □	_____ _____ _____
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 □	_____ _____

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

Has patient reached puberty? **NO □ YES □** **F**emale started menstruation? **NO □ YES □** Age ____ Male has voice changed? **NO □ YES □** Age ____

Has a physician indicated that the patient is **MATURING**: Normally? **NO □ YES □** Earlier than normal? **NO □ YES □** Later than normal? **NO □ YES □**

Did other children in the family mature: Early □ Normal □ Late □ Has the patient experienced a recent growth spurt? **NO □ YES □**

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 □**	_____
Emotional problems?	**NO □ YES □**	_____
Arthritis?	**NO □ YES □**	_____

Dental History:

Name of Patient's Dentist: _____ Phone: _____

Address: _____City: _____ State: _____ Zip Code: _____

Date of last visit: _____Reason: _____

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? _____	_____

History of:		Specifics of problem if *YES:*	Please explain…indicate any medication & dosage
Tooth Injury	**NO** ☐ **YES** ☐	Chipped ☐ Broken ☐ Lost ☐	_____
Jaw Injury	**NO** ☐ **YES** ☐	At age _____	_____
Jaw Joint Pain	**NO** ☐ **YES** ☐	Right side ☐ Constant ☐ Periodic ☐	When you: Chew ☐ Yawn ☐ Talk ☐ Open wide ☐
	NO ☐ **YES** ☐	Left side ☐ Constant ☐ Periodic ☐	When you: Chew ☐ Yawn ☐ Talk ☐ Open wide ☐
Jaw Joint Noises	**NO** ☐ **YES** ☐	Right side ☐ Constant ☐ Periodic ☐	_____
	NO ☐ **YES** ☐	Left side ☐ Constant ☐ Periodic ☐	_____
Jaw Joint Locking	**NO** ☐ **YES** ☐	Right side ☐ when open ☐ When closed ☐	Dates of locking: _____
		Left side ☐ When open ☐ When closed ☐	Dates of locking: _____
Grinding teeth	**NO** ☐ **YES** ☐	During the day ☐ When sleeping ☐	_____
Clenching teeth	**NO** ☐ **YES** ☐	During the day ☐ When sleeping ☐	_____
Bleeding Gums	**NO** ☐ **YES** ☐	Usually ☐ Sometimes ☐ Rarely ☐	Presently under a dentist's care for it? No ☐ Yes ☐
		When: Brushing ☐ Flossing ☐ Eating ☐	_____
Oral Habits	**NO** ☐ **YES** ☐	Thumb Sucking ☐ Finger Sucking ☐ Tongue Thrusting ☐ Nail Biting ☐ Lip Biting ☐	
Speech Problems	**NO** ☐ **YES** ☐	Lisping ☐ Speech Therapy ☐ At what age? _____ for what sounds? _____	
Other Oral Problems	**NO** ☐ **YES** ☐	If YES, please explain: _____	

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**

I understand that where appropriate, credit bureau reports may be obtained

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

_____

Signed: _____ Date Signed: _____
(Parent or Guardian)

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