Algirdas S. Vaitas, D.M.D., P.C.

(Please print and fill out completely)

BIRMINGHAM AND MILFORD ORTHODONTIC SPECIALISTS

Today's Date_____ Date of Birth_____ Age_____ SEX: M_____ F_____

Name(*first)*_____ (*middle)*_____ *(last)*_____

Address_____ City_____ State_____ Zip_____

Telephone(*home*)_____ *(cell)*_____ (work)_____

Email _____

Family Dentist_____ City_____ Phone_____

Family Physician_____ City_____ Phone_____

Employed by_____ Occupation_____

Employer's Address_____ City_____ State_____ Zip_____

Dental/Orthodontic Insurance YES ☐ NO ☐

Single ☐ Married ☐ Widowed ☐ Divorced ☐

Spouse's Name_____ Date of Birth_____ Phone_____

Email _____

Occupation_____ Employed by_____ City_____

Names and ages of Children_____

MEDICAL HISTORY

General Health: Good ☐ Fair ☐ Poor ☐

Presently under medical care for_____

Birth Defects_____

Medication currently being taken *(drug and dose)*_____

Allergic to (medication, metal, etc..)_____

Please check yes or no to the following and date:

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Adenoids (removed)	☐	☐	_____	Ear/Nose infections	☐	☐	_____	Glaucoma	☐	☐	_____	Rheumatic Fever	☐	☐	_____
Arthritis	☐	☐	_____	Emotional	☐	☐	_____	Heart disorder/ murmur	☐	☐	_____	Scoliosis	☐	☐	_____
Blood/Bleeding problems	☐	☐	_____	Endocrine disorder	☐	☐	_____	Hepatitis	☐	☐	_____	Speech difficulty	☐	☐	_____
Bone disorder	☐	☐	_____	Epilepsy	☐	☐	_____	Hospitalized	☐	☐	_____	Tonsils (removed)	☐	☐	_____
Diabetes	☐	☐	_____	Fainting spells	☐	☐	_____	Lung disorder	☐	☐	_____	Sexually transmitted disease	☐	☐	_____

☐ ☐ Do you require antibiotic premedication prior to dental appointments? If yes, which antibiotics do you usually take?_____

Please give us any additional information or details where necessary_____

DENTAL HISTORY

Date of last dental check-up_____

Injury of trauma to the face or teeth_____

Jaw joint (TMJ problems): noise_____ pain_____ earaches/ringing_____ soreness & stiffness_____

Have you noticed or been diagnosed as having any of the following problems due to a poor bite?

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Worn or sore teeth	☐	☐	_____	Bone and gum recession	☐	☐	_____	Speech difficulty	☐	☐	_____
Loose teeth	☐	☐	_____	Headaches and/or jaw joint problems	☐	☐	_____	Bruxism and/or clenching	☐	☐	_____

Is there anything you would like to improve about your dental health, smile, or facial appearance? Describe major reason for seeking orthodontic treatment.

Other family members with similar dental conditions and/or orthodontic treatment_____

Have you had any experience with or seen another orthodontist? Yes ☐ No ☐ If yes, who?_____

How and when did you first hear about our office?_____

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

Comments/Concerns_____