

MANHATTAN FAMILY ORTHODONTICS



Kris Togias, D.M.D., PC
Olivier Nicolay, DDS, MMSc
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

CONFIDENTIAL MEDICAL-DENTAL HISTORY

DENTAL HISTORY – now or in the past have you had (please check):

- Yes No-Any teeth removed for any reason? _____
 - Yes No-Snoring, sleep apnea? PSG test date _____
 - Yes No-Supernumerary (extra) or congenitally missing teeth? _____
 - Yes No-Tooth grinding, jaw clenching, clicking or locking? _____
 - Yes No-Chipped or otherwise injured primary (baby) or permanent teeth? _____
 - Yes No-Pain in jaw? _____
 - Yes No-Teeth sensitive to hot or cold, teeth throb or ache? _____
 - Yes No-Difficulty chewing or jaw opening? _____
 - Yes No-Jaw fractures, cysts or mouth infections? _____
 - Yes No-Aware of loose, broken or missing fillings? _____
 - Yes No-“Dead teeth” or root canals treated? _____
 - Yes No-Any teeth irritating cheek, lip, tongue or palate? _____
 - Yes No-Periodontal problems, bleeding gums? _____
 - Yes No-Frequent canker sores or cold sores? _____
 - Yes No-Thumb, finger or sucking habit? Until what age? _____
 - Yes No-Any wisdom tooth problems? _____
 - Yes No-History of speech problems? _____
 - Yes No-Wisdom teeth removed? Date _____
 - Yes No-Ever had a prior orthodontic examination or treatment? _____
 - Yes No-Are you sensitive or self-conscious about your teeth? _____
 - Date of past treatment _____
 - Yes No-Presently wearing retainer/mouth guard? _____
 - Other concerns about your teeth not listed? _____
-

MANHATTAN FAMILY ORTHODONTICS

Member
American Association of
Orthodontists



Member
American Association of
Orthodontists



Kris Togias, D.M.D., PC
Olivier Nicolay, DDS, MMSc
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

MEDICAL HISTORY – now or in the past have you had (please check):

- Yes No-Birth defects or hereditary problems? _____
- Yes No-Bone fractures, any major accidents? _____
- Yes No-Rheumatoid or arthritic conditions? _____
- Yes No-Endocrine or thyroid problems? _____
- Yes No-Kidney problems? _____
- Yes No-Diabetes? _____
- Yes No-Cancer, tumor, radiation treatment or chemotherapy? _____
- Yes No-Stomach ulcer, GERD, or frequent heartburn? _____
- Yes No-Problems of the immune system? AIDS or HIV positive? _____
- Yes No-Hepatitis, jaundice or liver problems? _____
- Yes No-Fainting spells, seizures, epilepsy, or neurological problems? _____
- Yes No-Mental health disturbance or behavioral problems? _____
- Yes No-Vision, hearing problems other than corrective lenses? _____
- Yes No-History of eating disorder (anorexia, bulimia)? _____
- Yes No-Excessive bleeding or bleeding disorder? _____
- Yes No-High or low blood pressure? _____
- Yes No-Cardiovascular problems such as chest pain, heart attacks? _____
- Yes No-Hayfever, asthma, sinus trouble? _____
- Yes No-Stroke, inborn heart defects, heart murmurs, angina? _____
- Yes No-Tonsil or adenoid conditions? _____
- Yes No-Does your child chew or smoke tobacco? _____
- Yes No-Girls – are you pregnant? _____

List allergies to all medications, latex, or metals

List all medications, herbal supplements, or vitamins presently taken:

Describe any operations or surgery you have had, including dates:

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

MANHATTAN FAMILY ORTHODONTICS

Member
American Association of
Orthodontists®



Member
American Association of
Orthodontists®



Kris Togias, D.M.D., PC
Olivier Nicolay, DDS, MMSc
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice at my next visit. Furthermore, I consent to an orthodontic examination and treatment of my child.

Signed: _____ Date signed _____
(Parent or Guardian)

Signed: _____ Date signed _____
(Dental staff member receiving form)

FINANCIAL AGREEMENT

--- We accept assignment of MOST insurance plans. Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company.

--- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. We estimate your insurance payments according to your policy. WE DO NOT in any way guarantee that your insurance will pay this amount.

--- Your payment is due at every visit unless you have made a financial contract with our office with scheduled payment dates. Cash, check or credit card are expected at the time services are rendered.

--- I hereby authorize payment directly to Kristos Togias, DMD./Manhattan Family Orthodontics (if chosen to) the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.

--- A fee will be charged to your account if there is a history of broken appointments with less than 24 hours notice, including same day cancellations.

Parent or Guardian's Signature _____ Date _____