



Crofton Orthodontics
2410 Evergreen Road, Suite 101
Gambrills, MD 21054
410-721-3403
www.docrsmartin.com

Dr. Robert Martin
Dr. Robert Yoon

Date: _____

Patient's Name: _____ Preferred name: _____
First Name Last Name

Address: _____

Birth Date: _____ Age: _____ Gender: _____ General Dentist: _____

Email for Appointment Reminders: _____ Phone number for reminders: _____

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

Other Family Members in Treatment: _____

Responsible Party Information:

Name: _____ Marital Status: _____
First Name Last Name

Home Address: _____

Social Security Number: _____ Birth Date: _____ Relationship: _____

Email: _____ Home Number: _____ Cell Number: _____

Employed By: _____ Occupation: _____

Spouse's Information:

Name: _____
First Name Last Name

Home Address: _____

Social Security Number: _____ Birth Date: _____ Relationship: _____

Email: _____ Home Number: _____ Cell Number: _____

Employed By: _____ Occupation: _____

Primary Dental Insurance Information:

Policy Holders Name: _____ Birth Date: _____ SSN: _____

Insurance Company: _____ Insurance Co. Phone Number: _____

Insurance Company Address: _____

Member ID Number: _____ Group Number: _____

Secondary Dental Insurance Information:

Policy Holders Name: _____ Birth Date: _____ SSN: _____

Insurance Company: _____ Insurance Co. Phone Number: _____

Insurance Company Address: _____

Member ID Number: _____ Group Number: _____

Emergency Contact Information:

Name: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

Patient/Guardian Signature: _____ Date: _____

Health Questionnaire

Date: _____

Patient's Name: _____ Birth Date: _____

Date of Last Dental Visit: _____ Family Physician: _____

Have you ever had the following?

Orthodontic Consultation: Y/N Date: _____ Dr. _____

Orthodontic Treatment: Y/N Date: _____ Dr. _____

Do you have or have you had any of the following oral conditions?

Y	N	Sensitive teeth	Y	N	Bleeding gums	Y	N	Oral habits (thumb sucking, etc)
Y	N	Clenching or grinding	Y	N	Pain around ear	Y	N	Pain in the jaw, face
Y	N	Jaw joint sounds or pain	Y	N	Pain when opening mouth	Y	N	Snoring
Y	N	Bad breath	Y	N	Dry mouth	Y	N	Mouth breathing
Y	N	Swallowing Problems	Y	N	Food wedging between teeth	Y	N	Inability to floss between teeth
Y	N	Discolored teeth	Y	N	Swelling or lumps in the mouth	Y	N	Tobacco use

Do you have or have you had any of the following medical conditions?

Y	N	Asthma	Y	N	Congenital heart lesions/murmur	Y	N	Heart condition
Y	N	Diabetes	Y	N	Arthritis, swollen joints	Y	N	Tuberculosis
Y	N	Allergies	Y	N	Kidney problems	Y	N	Hepatitis type _____.
Y	N	Anemia	Y	N	Inflammatory Rheumatism	Y	N	Convulsions/Seizures/Epilepsy
Y	N	Liver disease	Y	N	Rheumatic fever	Y	N	Sinus problems
Y	N	Severe headaches	Y	N	Tonsil/adenoids removed	Y	N	High or Low blood pressure
Y	N	Eye problems	Y	N	Dizziness or fainting	Y	N	Venereal disease
Y	N	Nose bleeds	Y	N	Ear/Hearing problems	Y	N	Sleep Apnea
Y	N	Easy bruising	Y	N	Speech problems	Y	N	HIV positive
Y	N	ADD/ADHS	Y	N	Emotional problems	Y	N	Head/Face injury

If you have answered "yes" to any of the above, please explain: _____

Is patient allergic to latex, metal or vinyl? If yes, please explain: _____

Is patient currently under a physician's care? If yes, please describe _____

Has patient ever been hospitalized or had any serious illness? If yes, please describe _____

Does patient have any drug allergies? If yes, list medications _____

Is patient taking any medications? If yes, list medications _____

Female patients - could patient possibly be pregnant at the present time? _____

Has patient ever taken any medication for OSTEOPOROSIS? _____

Patient/Guardian Signature: _____ Date: _____