Print Form

KAMLESH G. PATEL, D.M.D., P.A.
ADULT REGISTRATION AND MEDICAL DENTAL HISTORY FORM (OVER 18 YEARS OF AGE)

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

Birth Date: _____ Age: _____ Sex: ❑Male ❑Female I Prefer To Be Called: _____

Home Phone No.: _____ Cell Phone No.: _____ Pager: _____

S.S.N. /S.I.N.: _____ DL No.: _____ State: ____ E-Mail: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Years with Employer: _____

Employer's Address: _____

Business Phone No.: _____ Patient is: ❑Single ❑Married ❑Partnered ❑Widowed ❑Separated ❑Divorced

Name of Spouse/Closest Relative: _____ Phone No.: _____

Relationship to patient: _____ Spouse Birth Date: _____ S.S.N.: _____

Name of Relative or Friend not living with you that we can contact in case of emergency: _____

Relationship to patient: _____ Emergency Contact Phone No.: _____

Who Is Financially Responsible For This Account? Financially Responsible Party must be present prior to beginning any treatment.

Last Name: _____ First Name: _____ Middle Name: _____

Address (if different than patients): _____

Home Phone No.: _____ Cell Phone No.: _____ Office Phone No.: _____

Who suggested that you might need orthodontic treatment? _____

How did you hear about our office? _____

Why did you select our office? _____

Name of your ❑Present ❑Previous Dentist: _____ Phone No.: _____

Date of Last Dental Visit: _____ Reason for the Last Dental Visit: _____

Present Dentist Address: _____

Name of your Physician: _____ Phone No.: _____

Address: _____

Do you have Insurance Coverage for Dental Treatment? ❑Yes ❑No **Insurance Coverage For Orthodontic Treatment? ❑Yes ❑No**

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employer Name: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employer Name: _____

Dental Insurance Company: _____ Group No.: _____

Medical Insurance Company Name: _____ Phone No.: _____

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A thorough, complete and accurately completed history is vital to a proper orthodontic evaluation. Treatment recommendations may be based upon the following responses. The answers provided below are for office records only and will be considered confidential. **Please mark the responses as yes, no, dk/u (don't know/understand).**

MEDICAL HISTORY:

Now or in the past, have you had:

❑Yes ❑No ❑dk/u Birth defects or hereditary problems?

❑Yes ❑No ❑dk/u Eye, Ear, Nose or Throat Conditions?

❑Yes ❑No ❑dk/u Tonsil or adenoid conditions?

❑Yes ❑No ❑dk/u Vision, hearing, taste or speech problems?

❑Yes ❑No ❑dk/u Frequent headaches, colds or sore throats?

❑Yes ❑No ❑dk/u Fainting spells, seizures, epilepsy or neurological problems?

❑Yes ❑No ❑dk/u Mental health disturbance or depression?

❑Yes ❑No ❑dk/u Asthma, Sinus trouble, hayfever or hives?

❑Yes ❑No ❑dk/u Endocrine, Thyroid, Diabetes, Immune system problems?

❑Yes ❑No ❑dk/u AIDS or HIV positive?

❑Yes ❑No ❑dk/u Hepatitis, jaundice or liver problems?

❑Yes ❑No ❑dk/u Polio, mononucleosis, tuberculosis, pneumonia?

❑Yes ❑No ❑dk/u Cancer, tumor, radiation treatment or chemotherapy?

❑Yes ❑No ❑dk/u Stomach ulcer or hyperacidity?

❑Yes ❑No ❑dk/u Loss of weight or poor appetite recently?

❑Yes ❑No ❑dk/u History of eating disorder (anorexia, bulimia)?

❑Yes ❑No ❑dk/u Rheumatoid, arthritic conditions or osteoporosis?

❑Yes ❑No ❑dk/u Have you had any bone fractures or any major accidents?

❑Yes ❑No ❑dk/u Cardiovascular problems (heart trouble, heart attack, angina, stroke, inborn heart defects, heart murmur, mitral valve prolapse, rheumatic heart disease, coronary insufficiency or any heart or related cardiovascular diseases or disorders or conditions)?

❑Yes ❑No ❑dk/u Chest pain, shortness of breath or swelling ankles?

❑Yes ❑No ❑dk/u High blood pressure or low blood pressure?

❑Yes ❑No ❑dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorders?

❑Yes ❑No ❑dk/u Kidney problems?

❑Yes ❑No ❑dk/u Tired easily?

❑Yes ❑No ❑dk/u Skin or dermatologic disorders?

❑Yes ❑No Do you currently have or have ever had a substance abuse problem?

❑Yes ❑No Do you smoke or chew tobacco?

❑Yes ❑No Do you eat a well balanced diet?

ARE YOU ALLERGIC OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

❑Yes ❑No ❑dk/u Local anesthetics (Novocaine or Lidocaine)

❑Yes ❑No ❑dk/u Aspirin

❑Yes ❑No ❑dk/u Ibuprofen (Motrin, Advil)

❑Yes ❑No ❑dk/u Penicillin or any other antibiotics

❑Yes ❑No ❑dk/u Sulfa drugs

❑Yes ❑No ❑dk/u Codeine or any other narcotics

❑Yes ❑No ❑dk/u Metals (jewelry, clothing snaps)

❑Yes ❑No ❑dk/u Latex or plastics (gloves, balloons)

❑Yes ❑No ❑dk/u Vinyl

❑Yes ❑No ❑dk/u Acrylic

❑Yes ❑No ❑dk/u Animals: (specify)_____

❑Yes ❑No ❑dk/u Foods (specify) _____

❑Yes ❑No ❑dk/u Any other substance(s) (specify) _____

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Are you presently taking any medication(s), nutrient supplements, herbal medications or any non-prescription (over-the-counter) medicines? Please list each medication.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

❑Yes ❑No Are you now taking or have taken in the past, medications known as "*Bisphosphonates".

*Bisphosphonates are medications prescribed by your physician for the treatment of a variety of difficult medical disorders. Bisphosphonate medication types that you may be taking or have taken, can be: Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate), Aredia (pamidronate), or Zometa (zoledronic acid). There may be some additional brand names in addition to the above, but they are all known as "bisphosphonates".

Are you **currently being treated by any other health care professional**?

For: _____

Date of the most recent physical examination? _____

Do you have any medical conditions or any problems that may interfere with orthodontic treatment or that we should know about? _____

_____

Do you have any physical problems or symptoms that we should now about?

_____

Have you ever had any **operations or surgeries or even been hospitalized?**

(Describe year/procedure): _____

_____

_____

_____

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FOR WOMEN ONLY:

❑Yes ❑No ❑dk/u Are you pregnant?

❑Yes ❑No ❑dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY:

Do your parents or siblings have or have ever had any of the following health problems? If so, please explain:

Jaw Size Imbalance: _____

Unusual dental problems: _____

Severe allergies: _____

Diabetes, Arthritis, Bleeding Disorders: _____

Any medical conditions that we should know about? _____

DENTAL HISTORY:

Now or in the past, have you had:

❑Yes ❑No ❑dk/u Permanent or "extra" (supernumerary) teeth removed?

❑Yes ❑No ❑dk/u Supernumerary (extra) or congenitally missing teeth?

❑Yes ❑No ❑dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

❑Yes ❑No ❑dk/u Teeth sensitive to hot or cold, teeth throb or ache?

❑Yes ❑No ❑dk/u Jaw fractures, cysts or mouth infections?

❑Yes ❑No ❑dk/u "Dead teeth" or root canals treated?

❑Yes ❑No ❑dk/u Bleeding gums, bad taste or mouth odor?

❑Yes ❑No ❑dk/u Periodontal "gum problems"?

❑Yes ❑No ❑dk/u Food impaction between teeth?

❑Yes ❑No ❑dk/u "Gum Boils", frequent canker sores or cold sores?

❑Yes ❑No ❑dk/u Thumb, finger, or sucking habit? Until what age? _____

❑Yes ❑No ❑dk/u Abnormal swallowing habit (tongue thrusting)?

❑Yes ❑No ❑dk/u History of speech problems? Any speech therapy in past?

❑Yes ❑No ❑dk/u Mouth breathing habit, snoring or difficulty in breathing?

❑Yes ❑No ❑dk/u Tooth grinding or jaw clenching?

❑Yes ❑No ❑dk/u Any pain or soreness of the muscles of the face or around the ears?

❑Yes ❑No ❑dk/u Difficulty in chewing or jaw opening?

❑Yes ❑No ❑dk/u Have you ever been treated for "TMD" or "TMJ" problems?

❑Yes ❑No ❑dk/u Aware of loose, broken or missing restorations (fillings)?

❑Yes ❑No ❑dk/u Any teeth irritating cheek, lip, tongue or palate?

❑Yes ❑No ❑dk/u Concerned about spaced, crooked or protruding teeth?

❑Yes ❑No ❑dk/u Any relative with similar tooth or jaw relationships?

❑Yes ❑No ❑dk/u Any wisdom ("third molars") tooth problems?

❑Yes ❑No ❑dk/u Had any serious trouble with any previous dental treatment?

Are you or have you been under another dentist's care?

Dentist: List each one: _____

Specialist: List each one: _____

How often do you brush per day? ❑ Once ❑ Twice ❑ After each meal

How often do you Floss per day? ❑ Once ❑ Twice ❑ After each meal ❑ Never

How often you see your family dentist for routine dental care?

❑ Regularly ❑ Sometimes ❑ Only when I have a problem ❑ Rarely ❑ Never

If braces or orthodontic appliances are indicated, would you have any objections in wearing braces or orthodontic appliances? ❑ Yes ❑ No

What is your primary concern? Why are you here? _____

_____

_____

Have you ever had a prior orthodontic examination or evaluation or any orthodontic or "TMJ" treatment by any other orthodontist or dentist(s)?
Please list each one including the dates of previous examinations and list any treatment(s) provided in the past or presently.

_____

_____

ACKNOWLEDGEMENT:

I hereby acknowledge that I have read and fully understand the above questions. I have answered the questions truthfully to the best of my knowledge and ability. I will not hold my orthodontist or any member of his or her staff or this office for any errors or omissions or if I have intentionally not answered any of the above questions that I have made in completion of this form. I can read and comprehend the English language. If there are any changes later on to this record and or medical and or dental information contained herein, I will so inform this practice in writing by completing and updating a history record(s) form.

I authorize the orthodontist(s) and his or her staff to perform any necessary dental and or orthodontic services that I may need during diagnosis and treatment as deemed appropriate. I understand that my orthodontic treatment fee covers only the treatment provided by this office and that treatment provided by other dental or medical professionals is not included in the fee for my orthodontic treatment.

CONSENT TO UNDERGO ORTHODONTIC RECORDS:

I understand that in order to provide a consultation, this office may take or require preliminary records that may include Photographs and or Radiographs and I hereby consent to the making of Preliminary Diagnostic Records to the above Doctor(s) for the above individual.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION:
I hereby authorize this office to provide other health care providers with information regarding the above individual's orthodontic findings and care as deemed appropriate. I understand that once released, the above doctors(s) and staff has (have) no responsibility for any further release by the individual(s) receiving this information.

CONSENT FOR THE USE OF RECORDS:
I hereby give my permission for the use of the orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

I understand that this office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signed: _____ Date: _____
(Patient)

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

BELOW AREA FOR OFFICE USE ONLY

DIRECTIONS TO MAPLE LAWN ORTHODONTICS

7625 Maple Lawn Boulevard | Suite 250 | Fulton | Maryland 20759
Phone 301.776.9500
E-Mail: Info@MapleLawnOrthodontics.com Website: www.MapleLawnOrthodontics.com

FROM BALTIMORE CITY:
Take I-95 S toward Washington – go 16.9 miles
Take Exit # 35 B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.0 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM CATONSVILLE:
Take Baltimore National Pike (US-40 W) – 4.4 miles
Take Left ramp onto US-29 S toward Columbia – go 9.1 miles
Take Exit # 15/Johns Hopkins Road/Gorman Road onto Johns Hopkins Road toward Montpelier Road – Go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the parking Lot

FROM CLARKSVILLE:
Take MD-32 E – go 2.6 miles
Take Exit # 17/Cedar Lane/Pindell School Road onto Sanner Road – go 2.0 miles
Continue onto Maple Lawn Blvd – go 0.6 miles
Make a Left into the parking Lot

FROM COLUMBIA/ELLICOTT CITY:
Take Columbia Pike (US-29 S) – go 3.5 miles (From Columbia) or go 7.4 miles (From Ellicott City)
Take Exit # 15/Johns Hopkins Road/Gorman Road onto Johns Hopkins Road toward Montpelier Road – Go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the parking Lot

FROM FAIRFAX, VIRGINIA:
Take I-495 E toward Bethesda/Silver Spring/Baltimore
Take I-95 N towards Baltimore – go 10.4 miles
Take Exit # 35B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.3 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM GREENBELT/COLLEGE PARK:
Take I-95 N towards Silver Spring/Baltimore – go 13.3 miles
Take Exit # 35B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.3 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM LAUREL:
From Main Street, take MD-216 – go 3.9 miles
Bear Left on Scaggsville Road (MD-216 W) go 0.5 miles
Turn Right on Maple Lawn Blvd – 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM OLNEY/HIGHLAND:
Take MD-108 E (Olney Sandy Spring Road) – go 5.0 miles
Turn Right on Scaggsville Road (MD-216) – go 3.1 miles
Turn Left on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bldg., onto the Parking Lot

FROM ROCKVILLE/GAITHERSBURG/GERMANTOWN:
Take I-270 S – towards Capital Beltway (I-495)
Merge onto I-495 E – go 5.4 miles
Take I-95 N towards Baltimore – go 10.4 miles
Take Exit # 35B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.3 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bldg., onto the Parking Lot

FROM TOWSON:
Take I-83 S towards Baltimore
Continue on I-695 W toward Pikesville/Washington – go 2.3 miles
Continue on I-695 S – go 7.7 miles
Take exit # 16B-A/Local Traffic/Frederick onto I-70 W toward # 16A/Frederick – go 4.3 miles
Take Left exit # 87A/Columbia/Washington onto US-29 S – go 10.7 miles
Take Exit # 15/Johns Hopkins Road/Gorman Road onto Johns Hopkins Road toward Montpelier Road – Go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the parking Lot

FROM OUR SILVER SPRING OFFICE:
Take Columbia Pike (US-29 N) – go 7.2 miles
Take Exit # 15/Johns Hopkins Road/Gorman Road – go 0.4 miles
Go around the circle onto Johns Hopkins Road – go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the Parking Lot