Todd K. Rowe, DMD, MS
11 Park Street, Leominster, MA 01453
(978) 537-6100

Patient Information

Date _____

Patient's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Birth Date ____/____/____ Sex _____

Employer _____ Work Phone _____

I provide consent to Dr. Todd Rowe to use my cell phone number to (Choose one or both) □ call or □ text regarding appointments. I also give consent for Dr. Todd Rowe to call my cell phone regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is _____ _____ (initial)

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

Main reason for orthodontic consultation/treatment: _____

What one area of Dental-Orthodontic treatment concerns you most?

Quality Cost Discomfort Time

Commitments that limit appointment availability: _____

How do you feel about the possibility of orthodontic treatment?

Excited Neutral Nervous/Anxious Not Interested in Treatment

Name of dentist: _____ Date of last dental visit _____

Dental History

Have you had prior orthodontic treatment or consultation? _____yes _____no Orthodontist? _____

Have there been injuries to the face, mouth, or teeth? _____yes _____no Describe _____

Have you ever experienced jaw joint pain/discomfort? _____yes _____no Describe _____

Have you had treatment for jaw joint problems? _____yes _____ no Describe _____

Do you have any missing or extra permanent teeth? _____yes _____no Describe _____

Please complete both sides of this form

Medical History

Name of physician _____ Date of last medical visit _____

Are you in good health? _____yes _____no

Are you currently being treated by a physician? _____yes _____no

Please circle all that apply:

Allergies, Asthma or Hay fever	Fainting spells or seizures	Diabetes
Hepatitis, Jaundice or Liver disease	Blood disorder or anemia	Arthritis
Heart Murmur or other heart condition	Tuberculosis	**Latex Allergy**

Any other medical problems? _____

Are you taking any medications? _____ yes _____no If so, what?_____

Are you allergic or sensitive to any medications? _____ yes _____no If so, what?_____

Do you take vitamins? _____ yes _____no

Are antibiotics required before dental treatment? _____ yes _____no

Could you be pregnant? _____ yes _____no

Do you have chronic ear pain or infections? _____ yes _____no

Are you a mouth breather? _____ yes _____no

Do you grind or clench your teeth? _____ yes _____no

Signature _____ Date _____

Staff Review _____

Please complete both sides of this form.