Dr. Rebecca Kuperstein, DDS, MPH, MS
539 SE Cesar Chavez (39th Ave)
Portland, Oregon 97214
(503) 236-3800
www.parksideortho.com

Parkside
Orthodontics

Appointment _____

ADULT PATIENT INFORMATION

Name _____ Preferred Name _____
(Last) (First) (MI)

Reason for orthodontic consultation _____

Have any family members been to our office before? ❑ Yes ❑ No Who? _____

How did you learn about our office? _____

Hobbies / Interests: _____

Patient Information

Address _____

City _____ Zipcode _____

Length of residence _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Occupation _____

Length of employment _____

Birthdate _____ Sex ___ M ___ F

SS# _____ Marital Status _____

Email _____

Other Responsible Party _____

Address _____

City _____ Zipcode _____

Length of residence _____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Occupation _____

Length of employment _____

Birthdate _____ Sex ___ M ___ F

SS# _____ Marital Status _____

Email _____

Relationship to patient _____

DENTAL INSURANCE INFORMATION

Please bring your insurance cards, or provide the following information:

Subscriber _____ DOB _____

SS # / ID # _____

Insurance Company _____

Telephone _____

Group# _____

Subscriber _____ DOB _____

SS # / ID # _____

Insurance Company _____

Telephone _____

Group# _____

DENTAL HISTORY

General Dentist _____ Date of last dental cleaning _____

Have you had orthodontic treatment before? ❑ **Yes** ❑ **No** _____

Have you had an orthodontic consultation for your current concern? ❑ **Yes** ❑ **No** _____

Have you ever been diagnosed with periodontal/gum disease? ❑ **Yes** ❑ **No** _____

Do you have any unfinished dental work (i.e. cleaning, fillings, crowns, periodontal treatment, etc)? ❑ **Yes** ❑ **No**

Are you seeking changes to your facial appearance or gumline? ❑ **Yes** ❑ **No**

MEDICAL HISTORY

Primary care physician _____ Phone _____

❑ **Yes** ❑ **No** Are you taking any medication(s) at this time? If yes, please list _____

_____

❑ **Yes** ❑ **No** Do you have any allergies? If yes, please list _____

❑ **Yes** ❑ **No** Do you need to need to take antibiotics prior to certain dental procedures?

If yes, please specify and give reason for this need _____

❑ **Yes** ❑ **No** Have you been diagnosed with sleep apnea?

❑ **Yes** ❑ **No** Have you taken any oral or IV bisphosphonates (ex. Fosamax, Actonel, Boniva, Didronel, Bonefos, Zometa, Aredia, Skelid)? If yes, how long have you taken this medication? _____

❑ **Yes** ❑ **No** Do you smoke? If yes, how many cigarettes / day? _____

❑ **Yes** ❑ **No** Females: Are you pregnant?

Check any of these that you have or have ever had: ____ NONE

❑ AIDS/HIV+	❑ Bleeding Disorders	❑ Epilepsy/Seizures	❑ Previous Surgery	❑ Unfavorable Dental Experience(s)
❑ Anemia	❑ Birth Defects	❑ Diabetes	❑ Hepatitis	❑ Psychological Therapy
❑ Arthritis	❑ Cerebral Palsy	❑ Hearing Problem	❑ Injury to Head	❑ Radiation or Cancer Therapy
❑ Asthma	❑ Cold Sores	❑ Heart Condition	❑ Kidney Disease	❑ Tonsils/Adenoids Surgery
❑ Oral Ulcers	❑ Rheumatic Fever	❑ Speech Therapy	❑ Lung Disease	❑ Injury to Face/Teeth/Gums

Do you have any other condition not listed above? Please explain _____

_____

_____

Signature _____ Today's date _____

Member American Association of Orthodontists

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Future medical/dental updates:

Date _____ Changes _____ Signature _____

Date _____ Changes _____ Signature _____

Date _____ Changes _____ Signature _____

Date _____ Changes _____ Signature _____