



Pitts Orthodontics

Thomas R. Pitts DDS MSD
Arnold C. Pitts DDS MSD
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4786 Caughlin Pkwy. #305
Reno, NV 89519
775-825-3400

Patient Information

Date _____

Name _____ Birthdate _____
Last First Middle

Residence _____
Street City/State Zip

Home phone _____ Mobile phone _____ Email _____

School _____ Grade _____ Nickname: _____ Sex: _____

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

Do we see any other family members in the practice? _____

Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Relationship to Patient: _____ D.O.B. _____

Mailing Address _____
Street City/State Zip

Home phone _____ Work phone _____ Mobile phone _____

Email _____ SSN: _____

Employer _____ Occupation _____ No. years employed _____

Spouse Name _____ Marital Status _____
Last First Middle

Relationship to Patient: _____ D.O.B. _____

Mailing Address _____
Street City/State Zip

Home phone _____ Work phone _____ Mobile phone _____

Email _____ SSN: _____

Employer _____ Occupation _____ No. years employed _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature parent/patient _____ **Print Name:** _____

Additional Persons Responsible for Account

Name _____ Marital Status _____
Last First Middle

Relationship to Patient: _____ D.O.B. _____

Mailing Address _____
Street City/State Zip

Home phone _____ Work phone _____ Mobile phone _____

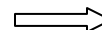
Email _____ SSN: _____

Employer _____ Occupation _____ No. years employed _____

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Home phone _____ Work phone _____ Relationship to patient _____



MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? Please list _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any major operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Do you have a tendency to colds? _____
- Yes No Have tonsils been removed? _____
- Yes No Have adenoids been removed? _____
- Yes No Do you have any speech problems? _____
- Yes No Are you pregnant?
- Yes No Are/Have you taking any medications for Osteoporosis? (Bisphosphonates, Fosamax, Boniva, Actonel, Reclast)
If Yes, for how long have you taken them? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|------------------------|-----------------|
| Abnormal bleeding/Hemophilia | Dizziness | High Blood Pressure | Tuberculosis |
| Allergies | Epilepsy | HIV / Aids | Tumor or Cancer |
| Anemia | Gastrointestinal Disorders | Kidney disease | Ulcers |
| Arthritis | Hay Fever | Latex/Rubber allergy | |
| Artificial Joints/Valves | Heart Disease | Nervous Disorders | |
| Asthma | Head Injuries | Pneumonia | |
| Blood Disorder | Heart Murmur | Prolonged Bleeding | |
| Bone Disorders | Hepatitis/Liver disease | Radiation/Chemotherapy | |
| Congenital Heart Defect | Herpes | Sinus Problems | |
| Diabetes | | | |

Are there any medical conditions we have not discussed that you feel we should be aware of?

DENTAL HISTORY

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Whom may we thank for referring you to our office, other than your dentist? _____

- Yes No Have you been informed of any missing or extra permanent teeth? _____
- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth or teeth? _____
- Yes No Is any part of your mouth sensitive to temperature or pressure? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes No Are you aware of your jaw clicking or popping? If yes when did it begin? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have "tension" headaches? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
- Yes No Are you aware that there will be appointments during school/work hours? _____

Are there any dental issues or conditions we have not discussed that you feel we should be aware of?

Updates (date & initial) _____ / _____ / _____ / _____ / _____ / _____ / _____



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Airway Questionnaire

Do you have difficulty breathing through your nose? No Yes; mild, moderate, severe

Do you breathe through your mouth when you sleep? No Yes; occasionally, always

Do you breathe through your mouth during the day? No Yes; occasionally, always

Do you snore? No Yes; mild, moderate, severe

Are you tired during the day? No Yes; mild, moderate, severe

Do you have sleep apnea? No Yes; mild moderate, severe

Do you have difficulties sleeping at night? No Yes; mild, moderate, severe

Do you clench and/or grind your teeth at night? No Yes; mild, moderate, severe

Do you wake up with headaches in the morning? No Yes; mild, moderate, severe

Do you wake up at night unable to catch your breathe? No Yes; occasionally, moderate severe

Do your legs and/or arms jerk at night? No, Yes

Do you sleep on your: back, sides, stomach

Do you have high blood pressure? No, Yes; mild, moderate, severe

Do you smoke? No, Yes; pack per day, cigarettes per day number of years

**PITTS ORTHODONTICS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have been offered a copy of this office's Notice of Privacy Practices, and have accepted or refused of my own choosing.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)