JOHN I. ESTERKYN
SPECIALIST IN ORTHODONTICS DDS • MS

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Please fill in the information requested within the boxes on both sides of this form.
A signature is required.

Patient Information

Date _____

Patient's Name _____ (Last / First / Middle) Male ☐ Female ☐

Address _____ (Street / City / State / Zip)

Home Phone (____) _____ Birthdate _____ Social Security # _____

Patient's interests _____ Name/Age of brothers & sisters _____

If patient is a minor, give parent's or guardian's name _____

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

Responsible Party Information

Name _____ (Last / First / Middle) _____ Marital Status

Residence _____ (Street / City / State / Zip)

Mailing Address _____ (Street / City / State / Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip) Email Address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last / First / Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Subscriber's Name _____ Subscriber's Soc. Sec. # _____ Birthdate _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Subscriber's Employer _____

Do you have dual coverage? Yes ☐ No ☐ If Yes:

Subscriber's Name _____ Subscriber's Soc. Sec. # _____ Birthdate _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Subscriber's Employer _____

I certify that the information on this form is complete and true to the best of my knowledge.

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

Signature (Parent's signature if minor) _____

Member
American Association of
Orthodontists

JOHN I. ESTERKYN, D.D.S., M.S.
ORTHODONTIC SPECIALIST

PATIENT'S MEDICAL HISTORY

Patient's Physician: Dr. _____ Phone # _____

Has patient had their tonsils or adenoids removed? yes no
Has patient ever had an unusual reaction to any drug? yes no
Has patient had any of the following?

[1] Arthritis yes no
[2] Anemia yes no
[3] Bleeding problem yes no
[4] Epilepsy/Seizures yes no
[5] Nervous disorder yes no
[6] Hyperactivity yes no
[7] Hepatitis yes no
[8] Venereal disease yes no
[9] Diabetes yes no
[10] Frequent colds yes no
[11] Allergies/Sinus yes no
[12] Asthma yes no
[13] Rheumatic Fever yes no
[14] Immune Deficiency yes no
[15] Herpes/Oral-facial yes no
[16] Ulcers yes no
[17] Major surgery yes no
[18] Tuberculosis yes no
[19] Heart trouble yes no
[20] Thyroid or Hormonal imbalance yes no
[21] Any other serious medical problems yes no

Does patient have a speech problem and if so, receiving speech therapy? yes no
Is patient presently under the care of a physician or taking medication? yes no

Signature (parent if minor) _____ Signature Doctor _____

Updated _____ Updated _____ Updated _____

PATIENT'S DENTAL HISTORY

Patient's General Dentist: Dr. _____ Phone# _____

Does the patient presently suck their thumb or fingers? please circle yes no
Does the patient breathe mostly through the mouth? yes no
Has the patient ever received a severe blow resulting in injury to the teeth or jaws? If yes, please write in details _____ yes no
Does the patient grind their teeth at night? yes no
In the past, has the patient ever complained of: please circle
clicking popping stiffness soreness in the jaw or jaw muscles?
Episodes when the jaw would not open or close normally? yes no
Pain or discomfort in the front of the ear? yes no
Headaches, neck and or back pain? yes no
If yes, please write date and details: _____
Has patient ever had orthodontic treatment or worn a retainer before? yes no
Would patient object to wearing orthodontic appl. should they be indicated? yes no
What is patient's or parent's primary concern? _____

Comments: _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____