MISO
ORTHODONTIC STUDIO

ADULT PATIENTS

New Patient Form

Please complete as much of this form as you can. Your answers are confidential and help us plan your care.

> **Please email your completed form to hello@misoortho.com at least 72 hours before your appointment.**
> This is important so we can prepare for your appointment and know your insurance benefits.
> Fill it out on your computer and save it, or print it, complete it by hand, and send a clear photo or scan.

PATIENT INFORMATION

Patient name (first, middle, last) _____ Birth date _____

Nickname (if preferred) _____ Age _____ Sex ◯ Male ◯ Female

Cell phone _____ Home phone _____ Email _____

Home address _____ City, State, ZIP _____

Occupation _____ General dentist _____

How did you hear about our office? _____

Have we treated another family member? ◯ Yes ◯ No If yes, name _____

Have you visited an orthodontist before? ◯ Yes ◯ No If yes, why _____

Is there anything you would like to discuss with the doctor in private? ◯ Yes ◯ No

INSURANCE INFORMATION

	PRIMARY	SECONDARY
Insurance company		
Company phone		
Group or plan #		
Member ID #		
Insured's name		
Insured's birth date		
Relationship to patient		
Insured's employer		

Name _____

HEALTH HISTORY

Check all that apply to you.

- ☐ ADD/ADHD
- ☐ High or low blood pressure
- ☐ Seizures, epilepsy or stroke
- ☐ Cold sores or herpes
- ☐ Endocrine problems
- ☐ Heart condition, angina or murmur
- ☐ Radiation therapy
- ☐ Tuberculosis
- ☐ Other (list below)
- ☐ AIDS/HIV infection
- ☐ Artificial joints
- ☐ Cancer or tumors
- ☐ Diabetes or hypoglycemia
- ☐ Eye, hearing or speech impairment
- ☐ Arthritis
- ☐ Hepatitis A, B or C
- ☐ Autism
- ☐ Allergies (list below)
- ☐ Heart valve disease or rheumatic fever
- ☐ Blood disorder or anemia
- ☐ Emotional disturbance
- ☐ Disability
- ☐ Asthma
- ☐ Bone disorder or bisphosphonate use
- ☐ Pregnant or possibly pregnant

Allergies

Current medications and doses

Other conditions not listed above

Are you under a physician's care now? ○ Yes ○ No If yes, for what _____

Do you have a history of major illness? ○ Yes ○ No If yes, please describe _____

Family physician _____ Phone _____ Date of last visit _____

DENTAL HISTORY

Check all that apply to you.

- ☐ Injury to face, mouth or teeth
- ☐ Tongue thrust
- ☐ Known extra permanent teeth
- ☐ Clenching or grinding teeth (day / night / both) _____
- ☐ Frequent headaches
- ☐ Muscle tenderness or stiffness in the jaw or neck
- ☐ Dizziness or ringing in the ears
- ☐ Thumb, finger or lip sucking habit
- ☐ Known missing permanent teeth
- ☐ Teeth removed year: _____
- ☐ Plays a musical instrument which: _____
- ☐ Pain, popping or locking when opening or closing the jaw
- ☐ Previous treatment for TMJ problems

Name _____

SLEEP AND AIRWAY SCREEN

These questions help us check whether trouble breathing during sleep may be affecting your health or your treatment. They are a screen, not a diagnosis.

	YES	NO	NOT SURE
Do you snore loudly (louder than talking, or heard through a closed door)?	○	○	○
Do you often feel tired, fatigued or sleepy during the day?	○	○	○
Has anyone seen you stop breathing, choke or gasp during sleep?	○	○	○
Do you have high blood pressure, or are you treated for it?	○	○	○
Do you wake up feeling unrefreshed, even after a full night in bed?	○	○	○
Do you wake with a headache in the morning?	○	○	○
Do you get up to urinate 2 or more times a night?	○	○	○
Do you have trouble concentrating, or do you nod off while reading, in meetings or while driving?	○	○	○
Do you have trouble breathing through your nose most days?	○	○	○
Have you had your tonsils or adenoids removed, or any nose or sleep surgery? Year: _____	○	○	○

SLEEP STUDY AND DIAGNOSIS

Have you ever had a sleep study?

○ Yes, overnight at a sleep center ○ Yes, a home test only ○ No ○ Not sure

If yes, when and where _____

Have you been diagnosed with sleep apnea?

○ Yes ○ No ○ Not sure

If yes, severity ○ Mild ○ Moderate ○ Severe ○ Don't know Treatment ☐ CPAP ☐ Oral appliance ☐ Surgery ☐ None

If you have had a sleep study, please send a copy of the report with this form or bring it to your first visit.

CONSENT AND SIGNATURE

I confirm that the information I have provided is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I understand that the sleep and airway questions are a screening only and not a diagnosis. I authorize the release of any information related to insurance claims, I consent to examination by the doctor, and I authorize payment of any insurance benefits.

Signature (type your full name or sign by hand) _____ Date _____

FOR OFFICE USE ONLY

BMI and neck circumference _____

Sleep study report received ○ Yes ○ No ○ N/A

Follow-up ☐ None ☐ Refer to physician / ENT / sleep medicine

Notes