PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Nickname_____ **Date of Birth**_____ Social Security #_____

School_____ Sports/Hobbies_____Gender(circle) Male / Female

Parent(s) or Guardian(s) name(s) _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address?_____

Previous address (if less than 3 years)_____

Cell phone_____ **Email address**_____

Home phone_____Work phone_____

Social Security #_____**Date of Birth**_____

Relationship to patient_____

Employer_____Occupation_____# years employed____

Spouse's Name_____Relationship to patient_____

Employer_____Occupation_____# years employed____

Social Security #_____Date of Birth_____

Cell phone_____Work phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____Insured's Social Security#_____

Insurance Company_____**Insured's Date of Birth**_____

Subscriber# / ID#_____Group#_____

Insurance Co. claims mailing address_____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____Insured's Social Security#_____

Insurance Company_____**Insured's Date of Birth**_____

Subscriber# / ID#_____Group#_____

Insurance Co. claims mailing address_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Address_____

Phone_____

MEDICAL HISTORY

Physician_____ Date of last visit_____
Address_____ Phone_____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication?_____
Yes No Is the patient allergic to any medication?_____
Yes No History of a major illness?_____
Yes No Has the patient had any operations?_____
Yes No Ever been involved in a serious accident?_____
Yes No Has the patient seen a physician in the last 12 months? Why?_____

Female patients only:

Yes No Has menstruation started?_____
Yes No Is the patient pregnant?_____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay Fever	Gastrointestinal Disorders	HIV/AIDS	Rheumatic Fever
Bone disorders	Heart problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous disorders	Tumor of Cancer

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

DENTAL HISTORY

General Dentist_____ Date of last visit_____
Address_____ Phone_____
What concerns you most about your teeth?_____

Yes No Is the patient presently in any dental pain?_____
Yes No Ever experienced any unfavorable reaction to dentistry?_____
Yes No Has the patient ever lost or chipped any teeth?_____
Yes No Have there been injuries to the face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where?_____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do gums bleed when brushing?_____
Yes No Any type of thumb or tongue habit?_____
Yes No Is the patient a mouth breather?_____
Yes No Has the patient ever seen an orthodontist? If yes, who and when?_____
Yes No What is the patient's attitude toward receiving orthodontic treatment?_____
Yes No Has anyone in the family received orthodontic treatment?_____
How did they feel about the result?_____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?_____
Yes No Experience jaw clicking or popping?_____
Yes No Aware of clenching or grinding teeth during the day or at night?_____
Yes No Experience "tension" headaches?_____
Yes No Has the patient ever experienced chronic ringing in the ears?_____
Yes No Does the patient need extra help with instructions?_____
Yes No Is the patient sensitive or self-conscious about his/her teeth?_____
Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours?_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of teeth, in the general function of teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Niaraki, Dr. Fadiani, Dr. Baquerizo, and Dr. Hostage to perform a complete orthodontic evaluation.

Signature:_____ Date:_____