# Patient Information

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DATE_____ PATIENTS AGE_____

PATIENTNAME_____ _____ _____
LAST FIRST MIDDLE GENDER NICKNAME

ADDRESS_____

HOMEPHONE_____BIRTHDATE_____SOCIAL SECURITY_____

WHO IS ACCOMPANYING THE PATIENT TODAY?_____ RELATIONSHIP TO PATIENT_____

NAMES & AGES OF SIBLINGS/CHILDREN_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

DENTIST'S NAME_____DATE OF LAST VISIT_____

# Parent Information (if a minor)

**MOTHER**'S NAME_____ □ STEPMOTHER □ GUARDIAN DOB_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP

EMPLOYER_____OCCUPATION_____WORK/CELL PHONE_____HOME PHONE_____

**FATHER**'S NAME_____ □ STEPFATHER □ GUARDIAN DOB_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP

EMPLOYER_____OCCUPATION_____WORK/CELL PHONE_____HOME PHONE_____

# Responsible Party Information

NAME_____ MARITAL STATUS _____RELATION_____
LAST FIRST MIDDLE

BILLING ADDRESS_____
STREET CITY STATE ZIP

SS#_____DOB_____HOME PHONE_____WORK/CELL PHONE_____

EMPLOYER_____OCCUPATION_____NO.YEARS EMPLOYED_____

# Spouse Information

SPOUSE_____EMPLOYER_____OCCUPATION_____

SOCIAL SECURITY#_____BIRTH DATE_____WORK/CELL PHONE_____

# Insurance Information

INSURED'S NAME_____INSURED SOC. SEC.#_____

INSURANCE COMPANY_____INSURANCE PHONE NO._____GROUP NO._____

INSURANCE CO. ADDRESS_____

INSURED'S EMPLOYER_____INSURED BIRTHDATE_____

# Emergency Information

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU_____RELATION_____

COMPLETE ADDRESS_____

PHONE_____RELATIONSHIP_____

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.
SIGNATURE (Parent signature if minor)_____

CONFIDENTIAL (for record and pretreatment evaluation)

# Medical History

IS PATIENT IN GOOD HEALTH?_____YES ☐ NO ☐

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS?_____YES ☐ NO ☐

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS?_____YES ☐ NO ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE?_____ YES ☐ NO ☐

HAVE YOU **EVER** TAKEN BISPHOSPHONATE DRUGS (usually taken for osteoporosis)?_____YES ☐ NO ☐

IS THERE A POSSIBILITY THAT THE PATIENT IS PREGNANT?_____YES ☐ NO ☐

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN DIAGNOSED/TREATED:

| | | |
|---|---|---|
| DIABETES……☐ | TUBERCULOSIS…..……..☐ | ENDOCRINE PROBLEMS……...☐ |
| FEVER BLISTERS…..……...☐ | CEREBRAL PALSY……...…..☐ | PROLONGED BLEEDING…..…..☐ |
| HEART TROUBLE……..…☐ | EPILEPSY……..…☐ | FAINTING OR DIZZINESS……...☐ |
| RHEUMATIC FEVER……...☐ | ASTHMA……...☐ | NERVOUS DISORDERS…..……..☐ |
| BONE DISORDERS..……...☐ | KIDNEY INVOLVEMENT…...☐ | LIVER INVOLVEMENT……...☐ |
| HEPATITIS…….……..…...☐ | GLAUCOMA……..☐ | HIGH/LOW BLOOD PRESSURE...☐ |
| | | OTHER…..……...☐ |

PLEASE DISCUSS ANY MEDICAL PROBLEMS_____

DOES PATIENT HAVE TENDENCY TO COLDS….☐ SORE THROATS….☐ EAR INFECTIONS….☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS_____

LIST ANY ALLERGIES OR DRUG SENSITIVITY_____

# Dental History

DATE OF LAST CLEANING_____ANY DENTAL WORK PENDING?_____

DOES THE PATIENT REQUIRE PREMEDICATION FOR DENTAL PROCEDURES?_____ YES ☐ NO ☐

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?_____ YES ☐ NO ☐

HAS THE PATIENT EVER HAD ANY PAIN/TENDERNESS IN THE JAW JOINT (TMJ)?_____ YES ☐ NO ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE?_____ YES ☐ NO ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS?_____ YES ☐ NO ☐

HAS PUBERTY BEGUN (MENSTRUATION FOR GIRLS)?_____ YES ☐ NO ☐

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE YES ☐ NO ☐ WHILE ASLEEP YES ☐ NO ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH_____ YES ☐ NO ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT?_____ YES ☐ NO ☐

HAS PATIENT HAD PRIOR ORTHODONTIC TREATMENT?_____ YES ☐ NO ☐

REASON FOR CONSULTATION_____

WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH FOR YOU?_____

# Benefits/Signature

Benefits of Orthodontics: Aesthetics, Health and function. Orthodontics is a service that provides an improvement in the appearance of the 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 understand this paragraph, and I also understand that it is my responsibility to inform this office of any changes in the patient's medical status.

The information I have given is correct to the best of my knowledge, and it will be held in the strictest of confidence.
I authorize Dr. Shae Ochoa and dental staff to perform the necessary dental services needed.

_____ _____ _____

SIGNATURE (parent signature if minor) RELATIONSHIP TO PATIENT DATE