Fullerton ORTHODONTICS

1 Tell Us About You

Today's Date:_____

Your Name:_____
Last First M. Ini.

I prefer to be called: _____ ❑ Female ❑ Male

Birthdate: _____ Age: _____

SSN:_____

Hobbies/Sports: _____

Home#: ( )_____ Work#:( )_____

Cell #: ( )_____

to receive confirmations via text: _____

Email address: _____

Home Address:_____

_____
City State Zip

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑Separated

Whom may we thank for referring you? _____

Other family members seen by us:_____

_____

General Dentist:_____

Last Exam Date:_____Any cavities?_____

Any proposed treatment? _____

2 Spouse Information

Name:_____

Wk#:( ) _____ Ext._____

Cell#:( )_____

3 Person Responsible For Account

Name:_____ Relation:_____

Billing Address:_____

_____
City State Zip

Hm#: ( )_____ TDL#:_____

Employer:_____

Wk#: ( )_____Ext._____

SSN:_____

Birthdate:_____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____

Relation:_____ Work#_____

Home#_____ Cell#_____

4 Dental Insurance

Orthodontic coverage? ❑Yes ❑ No ❑ Unsure

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#: ( )_____

Group# (Plan, local, or Policy #):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's DOB:_____

Policy Owner's SSN:_____

Policy Owner's Employer: _____

Secondary Dental Insurance

Orthodontic coverage? ❑Yes ❑ No ❑ Unsure

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#: ( )_____

Group# (Plan, local, or Policy #):_____

Policy Owner's Name:_____

Relationship to Patient:_____

Policy Owner's DOB:_____

Policy Owner's SSN:_____

Policy Owner's Employer: _____

5 Dental History

Have you ever had a serious/difficult problem associated with any previous dental work? Y N

Your current dental health is:

❑ Good ❑ Fair ❑ Poor

Do your gums bleed every time you brush? Y N

Do you generally breathe through your mouth? Y N

Awake? Y N During Sleep? Y N

Have there been any injuries to the face, mouth, teeth or chin? Y N

Have adenoids or tonsils been removed? Y N

Have you been informed of any missing or extra permanent teeth? Y N

Have you ever had any pain / tenderness in your jaw joint (TMJ/TMD)? Y N

Y N	Clenching/Grinding	Y N	Food impaction
Y N	Lip Sucking/Biting	Y N	Pain around ear
Y N	Bad Breath	Y N	Burning Tongue
Y N	Nail/Cheek Biting	Y N	Tongue Thrust
Y N	Use Dental Floss	Y N	Water Jet Device

Y N Fluoride supplements

Y N Teeth senstive to cold,heat, sweets or pressure

Y N Swelling or lumps in mouth

Y N Periodontal Treatment

Y N Cigarette/Tobacco use

6 What would you like orthodontics to accomplish?

_____

_____

_____

Have you ever been evaluated or had orthodontic treatment before? Y N

Do you like your smile? Y N

Did your regular dentist recommend treatment? Y N

Do you plan to whiten your teeth after treatment? Y N

Do you plan to have cosmetic bonding/veneers? Y N

7 Medical History

Physician: _____

Phone#: ( )_____

Date of Last Visit:_____

Are you currently under the care of a physician? Y N

Please describe your current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that you are currently taking:

_____

_____

_____

Are you allergic to any of the following?:

Y N Aspirin Y N Codeine Y N Any Metal/Plastic

Y N Penicillin Y N **Latex** Y N **Nickel**

Other drugs:

_____

_____

Hospitalizations:

_____

_____

Women:

Are you currently pregnant? Y N

If yes, due date? _____

8 Have You Ever had any of the following medical problems:

Y N Abnormal Bleeding
Y N Malignancies
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Any Operations
Y N Arthritis
Y N Artificial Valves
Y N Asthma
Y N Hay Fever/Allergies
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Glaucoma
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Heart Ailments
Y N Anemia/Hemophilia
Y N Heart Attack
Y N High/Low Blood Pressure
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Psychiatric Care
Y N Pregnancy

Y N Thyroid Issues
Y N Epilepsy/Seizures
Y N Radiation Treatment
Y N Joint Replacement
Y N Stroke
Y N Difficulty Breathing
Y N Eye Disorders
Y N Ulcers/Colitis
Y N Veneral Disease
Y N Drug Abuse
Y N Emphysema
Y N Tuberculosis (TB)
Y N Fever Blisters
Y N Hepatitis
Y N Pacemaker
Y N Headaches
Y N Migraines
Y N Shingles
Y N Sinus Problems
Y N HIV +/ AIDS

Is there anything not listed above that you feel that we need to be informed about? Y N

If Yes, Please describe:

_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____

Signature Date

I authorize and direct payment of the dental benefits offered by my dental insurance for treatment performed to Fullerton Orthodontics. I consent to your use and disclosure of my protected health information to carry out payment activites in connection with treatment performed.

_____

Signature Date

DOCTOR USE ONLY BELOW

I verbally retrieved the medical / dental information above with the patient named herein.

Doctor's Comments Initials: _____ Date: _____

_____

_____