

# Fullerton

## ORTHODONTICS

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### 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? \_\_\_\_\_

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### SPOUSE INFORMATION

Name: \_\_\_\_\_

Wk#: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

Cell#: ( ) \_\_\_\_\_

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### 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# \_\_\_\_\_

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### 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: \_\_\_\_\_

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### 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 sensitive to cold, heat, sweets or pressure

Y N Swelling or lumps in mouth

Y N Periodontal Treatment

Y N Cigarette/Tobacco use

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**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

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**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? \_\_\_\_\_

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 activities 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:**

- |                             |                          |
|-----------------------------|--------------------------|
| Y N Abnormal Bleeding       | Y N Thyroid Issues       |
| Y N Malignancies            | Y N Epilepsy/Seizures    |
| Y N Allergic to Plastics    | Y N Radiation Treatment  |
| Y N Any Hospital Stays      | Y N Joint Replacement    |
| Y N Any Operations          | Y N Stroke               |
| Y N Arthritis               | Y N Difficulty Breathing |
| Y N Artificial Valves       | Y N Eye Disorders        |
| Y N Asthma                  | Y N Ulcers/Colitis       |
| Y N Hay Fever/Allergies     | Y N Venereal Disease     |
| Y N Cancer/Chemotherapy     | Y N Drug Abuse           |
| Y N Congenital Heart Defect | Y N Emphysema            |
| Y N Glaucoma                | Y N Tuberculosis (TB)    |
| Y N Diabetes                | Y N Fever Blisters       |
| Y N Handicaps/Disabilities  | Y N Hepatitis            |
| Y N Hearing Impairment      | Y N Pacemaker            |
| Y N Heart Murmur            | Y N Headaches            |
| Y N Mitral Valve Prolapse   | Y N Migraines            |
| Y N Heart Ailments          | Y N Shingles             |
| Y N Anemia/Hemophilia       | Y N Sinus Problems       |
| Y N Heart Attack            | Y N HIV +/- AIDS         |
| Y N High/Low Blood Pressure |                          |
| Y N Kidney/Liver Problems   |                          |
| Y N Rheumatic/Scarlet Fever |                          |
| Y N Psychiatric Care        |                          |
| Y N Pregnancy               |                          |

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

If Yes, Please describe: \_\_\_\_\_  
\_\_\_\_\_

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**FULLERTON ORTHODONTICS**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I, \_\_\_\_\_, give my permission for Dr. Fullerton's office to discuss my/my child's treatment, treatment options or payment options with the following people:

Patient's Name: \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of receiving this office's Notice of Privacy Practices but was unable to do as documented:

Date: \_\_\_\_\_

Employee: \_\_\_\_\_

Reason: \_\_\_\_\_