

WELCOME

TO

Santa Rosa Orthodontics

The benefits of a happy, healthy smile are immeasurable!
A beautiful smile is a wonderful asset.

Tell Us About Yourself

Date: _____
Name: _____
I prefer to be called: _____
Gender: _____
Email: _____
Birthdate: ____/____/____
Age: _____
Home #: _____
Home Address: _____

Person Responsible For Account

Name: _____ Relation: _____
Billing Address: _____

Years at current address: _____ Rent _____ Own _____
Hm#: _____ Wk# _____ Ext. _____
SS#: _____ DL#: _____
Birthdate: ____/____/____
Employer: _____
Job title: _____ Years there: _____
Where/When best time to reach you: _____
Whom may we thank for referring you? _____
Other Family Members seen by us? _____
Other events you have seen us: _____ Sports teams
_____ Schools _____ Community events _____ Website
_____ Other
Please specify: _____
General Dentist: _____ Last visit Date: _____
Marital Status: _____

Spouse Information

Name: _____
Birthdate: ____/____/____
Employer: _____
Job Title: _____
Wk# _____ Ext. _____
SS# _____

Primary Orthodontic Insurance

Orthodontic Coverage? Yes ___ No ___

Name: _____
Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
Group#: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____
ID# _____
Policy Owner's Employer: _____

Secondary Orthodontic Coverage

Name: _____
Insurance Co. Name: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
Group#: _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: ____/____/____
ID#: _____
Policy Owner's Employer: _____

Medical History

Do you have any serious medical issues? Y ___ N ___
Do you have a personal physician? Y ___ N ___
Physician's Name: _____
Phone #: _____
Date of Last Visit: _____

Medical History Continued

What are the main concerns that you would like the orthodontist to accomplish? _____

Have you ever been evaluated for orthodontic treatment before? **Y**__ **N**__

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

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? **Y**__ **N**__

Your current dental health is:
Good ___ **Fair** ___ **Poor** ___

Do you like your smile? **Y**__ **N**__

Gums ever bleed? **Y**__ **N**__

Have you had an injury to your mouth? **Y**__ **N**__

Do you have any speech problems? **Y**__ **N**__

Do you breathe through your mouth? **Y**__ **N**__

If yes, please circle:

While Awake? While Asleep?

Do you have any missing/extra teeth? **Y**__ **N**__

Have you ever taken Fosamax, or any other Bisphosphonate? **Y**__ **N**__

Have you ever taken Phen-Fen? **Y**__ **N**__

Do you smoke /use tobacco in any form? **Y**__ **N**__

Thank you for filling out this form completely.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status. I also understand that for training purposes only, this office will occasionally film their office and clinical procedures. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

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

Name: _____ **Relation:** _____

Wk#: _____ **Hm# :** _____

Your current physical health is: **Good**__ **Fair**__ **Poor**__
Are you currently under the care of a physician? **Y**__ **N**__
Please explain: _____

Are you taking prescription/over the counter drugs? **Y**__ **N**__
Please list each one: _____

For Women: Are you using a prescribed method of birth control? **Y**__ **N**__
Are you pregnant?: **Y**__ **N**__
Are you nursing?: **Y**__ **N**__

Have you ever had any of the following diseases or medical problems?

- | | |
|--|-------------------------------------|
| Y N Abnormal Bleeding | Y N Anemia |
| Y N Artificial Bones /Valves/Joints | Y N Asthma/Arthritis |
| Y N Cancer/ Chemotherapy | Y N Blood Transfusion |
| Y N Diabetes | Y N Congenital Heart Defect |
| Y N Drug/Alcohol Abuse | Y N Difficulty Breathing |
| Y N Epilepsy/ Seizure /Fainting | Y N Emphysema |
| Y N Glaucoma | Y N Fever Blisters/Herpes |
| Y N Heart Murmur | Y N Heart Attack /Stroke |
| Y N Hemophilia | Y N Heart Surgery/ Pacemaker |
| Y N Hepatitis | Y N High/Low Blood Pressure |
| Y N HIV+/AIDS | Y N Kidney Problems |
| Y N Hospitalized -any reason | Y N Psychiatric Problems |
| Y N Mitral Valve Prolapse | Y N Rheumatic/Scarlet Fever |
| Y N Radiation Treatment | Y N Shingles |
| Y N Severe/Frequent Headaches | Y N Sinus Problems |
| Y N Sickle Cell Disease/Traits | Y N Ulcers/Colitis |
| Y N Tuberculosis (TB) | |
| Y N Venereal Disease | |

Please list any serious condition(s) you have ever had:

Are you allergic to any of the following?

- | | |
|--------------------------------|-------------------------|
| Y N Asprin | Y N Erythromycin |
| Y N Any Metals/Plastics | Y N Latex |
| Y N Codeine | Y N Penicillin |
| Y N Dental Anesthetics | Y N Tetracycline |
| Y N Other | |

Please list any drugs/materials you are allergic to:

OFFICE USE ONLY

OFFICE USE ONLY

OFFICE USE ONLY

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's comments: _____

Initials: _____ Date: _____