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 nor 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? WhileAsleep?

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

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

Are you allergic to any of the following?

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

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:_____**
_____
_____