ADVANCED ORTHODONTIC CARE

Azizorthodontics.com

Orthodontics for Children and Adults

Welcome! Thanks for choosing our office.

Patient Information:

(Confidential)

Date: _____

Full Patient Name: _____

Nickname: _____

DOB: _____ ☐Female ☐Male

Primary Home Address: _____

_____

_____

If you have siblings who are patients here, please list their name(s) & age(s):

_____

Phone Number: _____

☐Patient ☐ Mom ☐Dad ☐ Other: _____

Secondary Phone Number: _____

☐Patient ☐ Mom ☐Dad ☐Other: _____

Email: _____

Please Choose One:

☐ Minor ☐Single ☐ Married ☐ Separated

☐Divorced ☐ Widowed

If a student, name of school/college?

_____

Patient, parent, or guardian, employer:

_____

Occupation: _____

Whom may we thank for referring you?

_____

Dentist Information:

Name of Dentist: _____

Name of Practice: _____

Address: _____

_____

Office Phone Number: _____

Responsible Party Information:

(Confidential)

Same as patient info, check this box ☐

Name of person responsible for Account: _____

Relationship to Patient: _____

Address: _____

_____

_____

Phone Number: _____

Date of Birth: _____

Employer: _____

Occupation: _____

Insurance Information:

(Confidential)

Insurance Company: _____

Policy/ID #: _____

Name on Policy: _____

DOB: _____ SSN: _____

Have you used this policy for orthodontic treatment in the past? ☐ Yes ☐ No

Additional Insurance:

Insurance Company: _____

Policy/ID #: _____

Name on Policy: _____

DOB: _____ SSN: _____

Have you used this policy for orthodontic treatment in the past? ☐ Yes ☐No

Medical History: (confidential)

Full Patient Name: _____

Yes No

☐ ☐ Are you currently under the care of a physician? _____

☐ ☐ Have you ever been hospitalized or had a serious illness? Please explain: _____

☐ ☐ Are you taking any prescription or over the counter medication? Please list: _____

_____

☐ ☐ For women: Are you pregnant? If so, due date: _____ Are you nursing? ☐ Yes ☐ No

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

Yes No

☐ ☐ Abnormal Bleeding
☐ ☐ Anemia/Radiation Treatment (circle)
☐ ☐ Artificial bones, joints, valves
☐ ☐ Any artificial prosthesis
☐ ☐ Asthma
☐ ☐ Arthritis
☐ ☐ Tuberculosis
☐ ☐ Blood Transfusion, if yes date: _____
☐ ☐ Cancer / Chemotherapy
☐ ☐ Congenital Heart Defect
☐ ☐ Drug / Alcohol Abuse
☐ ☐ Diabetes
☐ ☐ Difficulty Breathing
☐ ☐ Emphysema
☐ ☐ Glaucoma
☐ ☐ Epilepsy / Seizures / Fainting (circle)
☐ ☐ Fever Blisters / Herpes (circle)
☐ ☐ Heart Attack / Stroke (circle)
☐ ☐ Heart Murmur
☐ ☐ Heart Surgery / Pacemaker (circle)
☐ ☐ Hemophilia
☐ ☐ Hepatitis
☐ ☐ High / Low Blood Pressure (circle)
☐ ☐ HIV + AIDS
☐ ☐ Kidney Problems
☐ ☐ Mitral Value Prolapse
☐ ☐ Psychiatric Treatment
☐ ☐ Depression
☐ ☐ Bi-Polar Disorder
☐ ☐ Attention Deficit Disorder
☐ ☐ Rheumatic / Scarlet Fever
☐ ☐ Severe / Frequent Headaches
☐ ☐ Shingles
☐ ☐ Sinus Problems
☐ ☐ Ulcers / Colitis
☐ ☐ Liver Problems
☐ ☐ Handicaps / Disabilities,
☐ ☐ Hearing / Vision Impairment (circle)
☐ ☐ Venereal Disease

Please list any serious medical condition(s) that may not be listed above: _____

Are you Allergic to Any of the Following?

(Please check if you have an allergy to the item)

☐Aspirin ☐Any metal or plastics ☐ Codeine
☐ Latex ☐ Dental Anesthetics ☐Erythromycin
☐Penicillin ☐Tetracycline ☐ Any other drugs(s) or allergies: _____

Orthodontic Questionnaire:

Have you ever been evaluated for orthodontic treatment? _____

Have you ever had a serious / difficult problem associated with dental work?

_____

Do you now or have you ever experienced pain / discomfort in your jaw joint? (TMJ)(TMD) _____

Your current dental health is:
☐Good ☐Fair ☐Poor

Do you like your smile? _____
Do your gums bleed? _____

Have you ever had injury to your:
☐Mouth ☐Chin ☐Teeth

Do you have speech problems? _____

Do you generally breathe through your mouth?
☐While awake ☐ While asleep

What are your main concerns you would like orthodontic treatment to accomplish? _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform any dental services that I may need during diagnosis and treatment with my informed consent.

X _____

Signature / Signature of parent or guardian:

Date: _____

Office use only:

I verbally reviewed the medical/dental information above on the patient named herein.

Initials: _____ *Date:* _____