Confidential Patient Information
Please Print Clearly

Patient Information

Name (Last, First): ______________________ **Birthdate:** ________ **Age:** ____ **Sex: M / F:**____
Address: ______________________ **City:** ______________ **State:** _____ **Zip Code:** _____
Home Phone: ______________ **Cell Phone:** ______________
Social Security #: ______________ **Driver's License #:** ______________ **E-Mail:**______________________
School: ______________________ **City:** ______________________ **Grade:** __________
Whom may we thank for referring you to our office?:______________________________________
Dentist Name: ______________ **Address:** ______________________ **Phone #:** __________
Date of last Oral Hygiene Cleaning Appointment: ______________

Fecha de la última cita de limpieza de higiene oral: ______________________________

Father/Husband/Self

Name:______________ **Birthdate:** ________
Address: ______________________
City ______________ **State:** _____ **Zip Code:** _____
Cell Phone: ______________________
Employer:______________________
Address: ______________________
Occupation: ______________________
Work Phone: ______________________
Social Security: ______________________
Driver's License #: ______________________

Mother/Wife/Self

Name:______________ **Birthdate:** ________
Address: ______________________
City ______________ **State:** _____ **Zip Code:** _____
Cell Phone: ______________________
Employer:______________________
Address: ______________________
Occupation: ______________________
Work Phone: ______________________
Social Security: ______________________
Driver's License #: ______________________

If parents are Divorced, child living with: ______________________________________
Name of person(s) financially responsible for account: ______________________________
In case of emergency, contact (specify someone who does not live in your household):

Name:______________________ **Relationship:** ______________ **Phone:** ______________

Does patient have Dental Ortho Insurance? Yes No **(Please give receptionist insurance card to photocopy)**

Primary Insurance Co: ____ **Insurance Phone #:**____

Name of Insured: ____ **Birthdate:** __________________ **Social Security #:** _______________________

Member I.D. #: ____ **Group Number:** ____

Secondary Insurance Co: ____ **Insurance Phone #:**____

Name of Insured: ____ **Birthdate:** __________________ **Social Security #:** _______________________

Member I.D. #: ____ **Group Number:** ____

So we may bill your insurance, please sign.

I hereby authorize payment directly to Dr. Do Orthodontics of the insurance Benefits. I authorize this office to check my credit report and take necessary records for treatment as they become necessary. I understand that I am Financially responsible for any changes not covered by this authorization. I authorize Dr. Do Orthodontics to release any information relating to this claim.

____ ________________________

(Signature of insured) Date

Medical History

1. **Is patient in good health? Yes No If no, explain:**____

1. **Physician's name:** ____ **Phone Number:** ______________________________ **Is patient under a physicians care now? Yes No , If yes, explain:**____

1. **Is patient taking prescribed or any other over the counter medication?**.. **Yes No**
 If yes, list medication:____

4. **Has patient taken any weight loss medication?** …….. **Yes No**

4. **Has patient ever had a blood transfusion?**…… **Yes No**

4. **Does the patient smoke? Yes No Use tobacco? Yes No Use recreational drugs** ………………………………………………………………….. **Yes No**

4. **Has the patient ever had an allergic reaction to local anesthetic (e.g. novacaine)?**…………………………………………………………………………………………………... **Yes No**

4. **Is the patient allergic to any medication (e.g. penicillin)**…………………………………...…………………………………………………………………….……………………. **Yes No If yes, list medication:**____

4. **Is the patient allergic latex?** ……….. **Yes No**

4. **Has the patient ever had prolonged bleeding after n injury or extraction?** ……………………………………………………………………………………………………… **Yes No**

4. **Does the patient have a cardiac pacemaker or artificial valve?**…………………………………………………………………………………...……………………………… **Yes No**

4. **Is there any family history of diabetes, heart murmur/problems, tumors?**…… **Yes No**

4. **Does the patient's jaw pop or click when chewing? (TMJ)**……. **Yes No**

4. **Are you pleased with the appearance of your smile?**…… **Yes No**

4. **What would you like to discuss with the dentist today? Braces Second Opinion Other** ____

4. **Does the patient have any missing teeth? Yes No Does the patient have an orthodontic appliance?**……………………………………………………. **Yes No**

4. **Has patient had any disease, serious illness, surgery, condition or problem not listed below?**……………………………..………………………………………………… **Yes No**

4. **Is the patient pregnant?** ……..…………………………………………………

Yes No

4. Please check each box, individually, yes or no, if the patient has ever had any illness or condition listed below.

Health History Reviewed by: ____________________

Date: ____________________

Y N
- AIDS/HIV
- Arthritis
- Cancer
- Dizzy Spells
- Fainting
- Heart Bypass
- Hepatitis
- Jaundice
- Lung Cancer
- Rheumatic Fever
- Tuberculosis

Y N
- Allergies
- Artificial Joint
- Chemotherapy
- Emphysema
- Fever Blisters
- Heart Mur Mur
- High Blood Pressure
- Kidney Disease
- Nervous/Mental Disorder
- Sinus Trouble
- Venereal Disease

Y N
- Anemia
- Asthma
- Cold Sores
- Epilepsy
- Glaucoma
- Heart Problems
- HIV Positive
- Liver Problems
- Psychiatric Treatment
- Stroke
- Angina

Orthodontic Treatment Agreement

I give consent for an orthodontic evaluation and agree to be financially responsible for any orthodontic records.

Patients signature/ responsible party if patient is a minor ____________________ Date ____________________

Y N
- Bleeding Disorders
- Diabetes
- Emotional Disorder
- Heart Attack
- Heart Surgeries
- Immunosuppressed
- Low Blood Pressure
- Radiation
- Thyroid Problems

Medical History Update or Changes: Date: Comments: Signature:	Doctor Signature