ADULT PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle

Mailing Address_____
Street City Zip

Home phone_____ Work phone _____Cell phone_____

Nickname _____ Date of Birth_____ Social Security #_____

Employer_____ Occupation_____

Email Address_____

How did you hear about our office?_____

Spouse's Name_____ _____

Date of Birth _____ Cell phone _____Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____Insured's Social Security #_____

Employer_____

Insurance Company_____ Group No._____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Employer_____

Insurance Company_____ Group No._____ Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Complete address_____
Street City Zip

Phone_____

Appointment Reminders: two reminders will be sent (1 week and 2 days in advance of appointments)

Please list all email addresses where you would like us to send email reminders:

_____

Please list all cell phone numbers where you would like us to send text reminders:

_____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?

If yes, please list name and dosage _____

Yes No Have you ever taken any prescription medications for weight loss (diet pills)?

If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other

Yes No If yes to any of the above, did you have a medical exam for heart issues?

Yes No Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?

Yes No Are you allergic to any medication? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Have you ever smoked or chewed tobacco? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Are you pregnant? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have your wisdom teeth been removed? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

What is your attitude toward receiving orthodontic treatment? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have “tension” headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No Are you aware that some appointments will be during work hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Peralta to perform a complete orthodontic evaluation.

I acknowledge that the office of Dr. Jorge Peralta reserves the right to charge $50 per missed appointment, after the first missed appointment.

Signature: _____Date: _____