Dental / Medical History

& General Information

Bay Area Orthodontic Center

Patient's General Info.

Patient's Name: _____ Preferred Name: _____

Birth date .: _____ SS # : _____ Age: _____ Sex: M / F

Home Address: _____ City: _____ Zip: _____ Hm #: ( ) _____

Employer : _____ Occupation: _____ Employer Address: _____

Wk #: ( ) _____ Cell #: ( ) _____ Pager: ( ) _____ Email: _____@ _____

Spouse Name: _____ SS # : _____ Employer : _____ Wk #: ( ) _____

Emergency Contact: Name: _____ Relation: _____ Phone #: ( ) _____

How did you hear about us / Referred by: __ Insurance __ Your Dentist __ Web Site __ other: _____

Children in family: (Name & Age): _____

Does any relative have a similar bite? N - Y Who? _____ Other Friends or Relatives treated here: _____

Oral Health History

Dentist: _____ Dental Office Name : _____ Date of Last Check: _____

Address: _____ City: _____ Zip: _____ Phone: ( ) _____

What is your main Reason / Concern or Goal in seeking Orthodontic treatment now? __ Dental Health __ Cosmetics __ Dentist Referral __ Other: _____

_____

Have you ever had any Orthodontic treatment or consultations? N - Y If yes, please explain when and the outcome of the treatment: _____

_____

Is there any history of: (Circle)

N - Y Clicking of the Jaw Joints(TMJ)	N - Y Tongue thrusting / habit	N - Y Gum Problems
N - Y Pain in the Jaw Joints (ears)	N - Y Grinding teeth (Day / Night)	N - Y Extra Teeth
N - Y Injuries to the Teeth	N - Y Pen, lip, or nail biting	N - Y Extraction of teeth
N - Y Injuries to the Face	N - Y Thumb or finger sucking	N - Y Missing Teeth
N - Y Difficulty Chewing	N - Y Chewing Gum	N - Y Speech problem
N - Y Fever blisters / Ulcers	N - Y Mouth breathing	N - Y Dry mouth

If you have answered Yes to any of the above, please explain: _____

_____

Date Updated:					
Comments / Changes in Med / Dent. Hx. : _____ _____ _					

Medical History

Physician: _____ Are you under a physician's care presently? N - Y What for: _____
Address: _____ City: _____ Zip: _____ Phone: ( ) _____

Women: Are you Pregnant? N - Y Are you taking Birth control pills? N - Y Are you required to take antibiotics prior to Dental Visits? N - Y

Is there any history of: (Please Circle)

N - Y Heart Disease	N - Y Kidney disease	N - Y Nasal blockage	N - Y Emotional Problem
N - Y Rheumatic Fever	N - Y Diabetes	N - Y Drug / Alcohol use	N - Y Psychiatric Therapy
N - Y Heart Murmur	N - Y Seizures	N - Y Hepatitis / Jaundice	N - Y Digestive disorder
N - Y High Blood Press	N - Y Asthma	N - Y Tuberculosis	N - Y Hospitalization / Surgery
N - Y AIDS / HIV +	N - Y Arthritis	N - Y Thyroid disease	N - Y Blood / Bleeding disorder
N - Y Heart Surgery	N - Y Artificial Bones / Joints	N - Y Frequent colds	N - Y Unusual childhood disease
N - Y Artificial Valves	N - Y Cancer / Chemotherapy	N - Y Major illnesses	N - Y Birth defect

If you have answered Yes to any of the above, please explain. _____
Are you taking any medications? N - Y Please list names and reasons: _____
Do you have any allergies? N - Y What? Penicillin, Aspirin, Codeine, Erythromycin, Dental Anesthetics, Food, Metals, Plastic, Latex, Other: _____
Please list any other information, which you feel, may be of value in the treatment. _____

Financial

Primary person insured or responsible for the account: _____ Hm# ( ) _____ Wk #: ( ) _____

SS # : _____ Birth date : _____ Ca D.L. #: _____

Do you have insurance with Orthodontic coverage? N - Y Are you planning on using Pre-Tax Dollar? N - Y

Primary Dental Insurance Info

Insur. Co. name: _____ Tel #: ( ) _____
Address: _____
Insured Name : _____ Relation to Patient: _____
S.S.# : _____ Birthday: _____ Group / Plan ID #: _____
Employer : _____ Max Coverage: _$_____

Secondary Dental Insurance Info

Insur. Co. name: _____ Tel #: ( ) _____
Address: _____
Insured Name : _____ Relation to Patient: _____
S.S.# : _____ Birthday: _____ Group / Plan ID #: _____
Employer : _____ Max Coverage: _$_____

Consent

I hereby certify that I have filled out this form to the best of my knowledge and all the preceding answers are true and correct. I further, the undersigned, give full consent for performing any procedure, x-ray or exams deemed necessary for diagnosis and treatment recommended. I also authorize Bay Area Orthodontic Center to run a routine credit check if needed in extending a payment plan.

_____ _____/_____/_____
Patient / Parent/ Guardian Signature Date

OFFICE USE ONLY

Medical And Dental Hx. Reviewed by: _____ Date : _____

Doctor's Notes OR Significant Med. / Dent. Findings not listed above: _____

_____