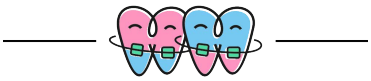
Dr. Bita Orthodontic Group



LIVE-LAUGH-SMILE

PATIENT INFORMATION

Date_____

Patient's name _____ Male ____ Female ____
First **Middle** **Last** **Nickname**

Address _____
Street City Zip

Home Phone_____Date of Birth_____Age_____Social Security # _____

If patient is a minor, please provide name(s) of parent(s)/guardian(s) _____

Whom may we thank for referring you to our office? _____

School_____Grade_____

Children/Sibling: Name(s)_____Date(s) of Birth_____Age(s) _____

Please list some hobbies or interests _____

RESPONSIBLE PARTY INFORMATION

Self/Parent/Guardian_____
First Middle Last

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

How long at this address?_____Home phone_____Work phone _____

Cell/other phone_____Email address_____

Social Security #_____Birthdate_____Relationship to Patient _____

Employer_____Occupation_____No. years employed _____

Marital Status: Single____ Married____ Divorced____ Widowed____

Spouse/Parent/Guardian/Other_____Relationship to Patient_____

Employer_____Occupation_____No. years employed _____

Social Security #_____Birthdate_____Work Phone_____

Person Financially responsible for this account: Self Spouse____Parent____Guardian____Other _____

DENTAL INSURANCE INFORMATION

(If Dental and/or Orthodontic Coverage, please provide card)

Insured's Name_____Date of Birth_____Social Security # _____

Employer _____

Insurance Company_____Group No._____Local No. _____

Insurance Co. Address_____Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes, complete the following:

Insured's Name_____Date of Birth_____Social Security # _____

Employer _____

Insurance Company_____Group No._____Local No. _____

Insurance Co. Address_____Phone No._____

EMERGENCY INFORMATION

Emergency Contact (nearest you)_____Relationship to Patient _____

Address_____Phone _____
Street City Zip

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

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

Yes No Are you in good health? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations or been hospitalized? _____
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? _____
Yes No Are you taking any prescription and/or over-the-counter medication? _____
Yes No Are you allergic to any medication or substance (including latex or metals)? _____
Yes No Have any tonsils or adenoids been removed? _____

Female Patients only:

Yes No Are you pregnant? _____
Yes No Are you nursing? _____

Children only:

Yes No Has the patient reached puberty? _____
Yes No Has the patient's menstruation begun (girls)? _____
Yes No Has the patient's voice changed (boys)? _____

Please circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Dizziness	Heart Problems	Pneumonia
Anemia	Endocrine Disorder	Hepatitis/Jaundice	Prolonged Bleeding
Arthritis	Epilepsy/Convulsions/	Herpes/Cold Sores	Psychiatric Problems
Asthma	Seizures	High/Low Blood Pressure	Radiation/Chemotherapy
Bone Disorders	Glaucoma	HIV+ / Aids	Rheumatic/Scarlet Fever
Bronchitis	Growth Disorder	Leukemia	Sexually Transmitted Disease
Cancer	Kidney Disease	Liver Disease	Sinus Problems
Congenital Heart Defect	Hay Fever/Allergies	Lung/Respiratory Problems	Stomach Trouble/Ulcers
Diabetes	Heart Attack/Stroke	Migraines/Severe Headaches	Thyroid Problems
Developmental Disorder	Heart Murmur	Nervous Disorders	Tuberculosis

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

_____

DENTAL HISTORY

General Dentist _____ Phone number _____
Date of most recent dental exam/cleaning/x-rays _____
What are the main concerns that you would like Orthodontics to address? _____

Yes No Have you ever had or been evaluated for Orthodontic treatment? _____
Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have you ever been informed of any missing or extra 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 Are you aware of your jaw joint clicking or popping (TMJ/TMD)? _____
Yes No Are you aware of clenching/grinding of your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Do you have any speech problems? _____
Yes No Are you a mouth breather? _____
Yes No Has anyone in your family received orthodontic treatment? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No If the patient is under age 18, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. In the event of a default on agreed upon payment arrangements, I am responsible for reasonable collection costs. I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Bita Moalej or Dr. David Sherwood to perform a complete orthodontic evaluation.

Signature (Parent/Responsible party if minor): _____ Date: _____
Doctor's signature (verbal review of medical information): _____ Date: _____

MEDICAL HISTORY UPDATES

Changes:
Parent/Guardian Signature _____ Date _____
Dental Staff Signature _____ Date _____