Patient Information

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐ Rev.☐ Other:_____

Patient Name:_____
First Middle Last (Name Called)

Birthday:_____

Home Phone:_____ Cell Phone:_____

Address:_____

Address:_____

City, State Zip Code:_____

Sex M☐ F☐ SSN:_____ Race:_____

Dentist:_____

Physician_____

Who referred you to our practice?_____

Any Medical Problems?_____

Responsible Party Information

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐ Rev.☐ Other:_____

Responsible Party Name:_____
First Middle Last (Name Called)

Birthday:_____

Home Phone:_____ Work Phone:_____

Address:_____

Address:_____

City, State ZipCode:_____

Sex M☐ F☐ SSN:_____ Relationship to Patient:_____

Is this Responsible Party Financially Responsible for Charges? yes☐ no☐

Is this the Primary Person who brings patient to appointments? yes☐ no☐

Insurance Company:_____

Group Number:_____ Phone:_____

Address:_____

Employer:_____

Address:_____

WERE YOU REFERRED BY:

Your Dentist: __ Name: _____ Friend/Family:__ Name:_____ Internet/Flyer: _____

Please provide us with your e-mail address:_____

Personal references *(please list three people who do not live with you, we can contact in case of an emergency)*

Name _____ *# Phone* _____ *Relationship* _____

Name _____ *# Phone* _____ *Relationship* _____

Name _____ *# Phone* _____ *Relationship* _____

Name of your dentist _____ ***Phone number*** _____ ***Date of the most recent dental exam/cleaning/x-rays*** _____

What are the main concerns that you would like Orthodontist to accomplish? _____ ***Are you happy with the way your smile looks?*** _____

On a scale of 1-10, how motivated are you to start orthodontic treatment? **1-3** **4-7** **8-10**

Health History

Please circle your answer:

Do you have a personal Physician? Yes No
Physician's name: _____
Phone #: (___) _____ *Date of last visit:* _____
Your current Physical Health is: Good Fair Poor
Do you smoke tobacco or use it in any form? Yes No
Have you had any metal rods, pins or implants? Yes No
Taking any prescription/over the counter drugs? Yes No
Please list each one: _____
Do you have any jaw joint pain? Yes No
Do you have any jaw joint clicking/popping? Yes No
If so when? _____
Do you take pre-medication for dental visits? Yes No
Do you take diphosphonates (for bone loss)? Yes No
Are you allergic to any of the following: (Circle)
Aspirin *Erythromycin* *Penicillin*
Codeine *Jewelry/Metals* *Tetracycline*
Dental Anesthetics *Latex* *Other:* _____
Please list each one: _____
Women: Are you taking birth control pills? Yes No
Are you pregnant? Yes No *Week #* _____
Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems? *(Please circle individually)*

Y N Abnormal Bleeding / Hemophilia	Y N High Blood Pressure
Y N AIDS	Y N HIV
Y N Alcohol/Drug abuse	Y N Hospitalized for any reason
Y N Anemia	Y N Kidney Problems
Y N Arthritis	Y N Liver Disease
Y N Artificial Bones / joints / valves	Y N Low Blood Pressure
Y N Asthma	Y N Lupus
Y N Autism / ADHD	Y N Mitral Valve Prolapse
Y N Blood transfusion	Y N Pacemaker
Y N Cancer / Chemotherapy	Y N Psychiatric Treatment
Y N Colitis	Y N Radiation Treatment
Y N Congenital Heart Defect	Y N Rheumatic / Scarlet Fever
Y N Diabetes	Y N Seizures
Y N Difficulty Breathing	Y N Shingles
Y N Emphysema	Y N Sickle Disease / Traits
Y N Epilepsy	Y N Stroke
Y N Frequent Headaches	Y N Thyroid Problems
Y N Glaucoma	Y N Tuberculosis (TB)
Y N Hay Fever	Y N Ulcers
Y N Heart Attack / Surgery	Other _____
Y N Hepatitis	_____
Y N Herpes / Fever blisters	_____

Our office reserves the right to verify the credit of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting service. 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 to payment arrangements, I am responsible for reasonable collection costs.

In order to maintain quality control and excellent customer service, Dr. Lili Mirtorabi, D.D.S., M.S Orthodontics may conduct video and audio surveillance. Video and audio monitoring is used to identify safety concerns, maintain quality control, detect theft and misconduct, and discourage or prevent acts of harassment and violence.

Signature (Parents/Responsible Party signature if minor) _____ ***Date*** _____

********** **For Office Use Below Only** **********

I verbally reviewed the medical information above with the patient named herein. ***Initials:*** _____ ***Date:*** _____

Doctor's Comments: _____