SOCAL DENTAL SPECIALISTS

Please Print

Confidential Patient Information
Date_____

Patient's Name_____ ☐ Male ☐ Female
Last   First   Middle

Address_____
Street   City   State   Zip

Home Phone_____ Birthdate_____ Email_____

Social Security_____General Dentist_____ City_____

Confidential Responsible Party Information

Name/Parent #1_____ Marital Status_____
Last   First   Middle

Address _____ ☐Own ☐ Rent
Street   City   State   Zip

How long at this address_____ Email_____

Phone: Home _____ Work _____ Cell _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____Occupation_____Years Employed_____

Spouse/Parent #2 _____ Marital Status _____
Last   First   Middle

Address _____ ☐Own ☐Rent
Street   City   State   Zip

How long at this address_____ Email_____

Phone: Home _____ Work _____ Cell _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____Occupation_____Years Employed_____

Patient lives with:
Both Parents Together   Both Parents Separately   Parent #1   Parent #2   Other:_____

Policy Holder's Name_____ Social Security #_____

Birthdate _____ Insurance Company_____ Insurance ID # _____

Insurance Co. Phone _____ Policy Holder's Employer _____

Do you have dual coverage?   Yes ☐ No ☐   If yes, please fill out below:

Policy Holder's Name_____ Social Security #_____

Birthdate _____ Insurance Company_____ Insurance ID #_____

Insurance Co. Phone _____ Policy Holder's Employer _____

☐ No Change ☐ Change _____ Patient/Guardian _____ Date _____ Doctor _____

☐ No Change ☐ Change _____ Patient/Guardian _____ Date _____ Doctor _____

☐ No Change ☐ Change _____ Patient/Guardian _____ Date _____ Doctor _____

MEDICAL HISTORY	DENTAL HISTORY

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Are you taking any prescription/over-the-counter medications?
☐ Yes ☐ No

Please list each one: _____

_____

For Women: Are you using a prescribed method of birth control?
_____ ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No   Week #:_____
Are you nursing?   ☐ Yes ☐ No

Have you ever had any of these medical conditions?

Y N Abnormal Bleeding   Y N Hepatitis
Y N High/Low Blood Pressure   Y N HIV+/AIDS
Y N Hospitalized for Any Reason Y N Cancer/Chemotherapy
Y N Congenital Heart Defect   Y N Mitral Valve Prolapse
Y N Diabetes   Y N Psychiatric Problems
Y N Difficulty Breathing   Y N Radiation Treatment
Y N Drug/Alcohol Abuse   Y N Severe/Frequent Headaches
Y N Epilepsy/Seizures/Fainting Y N Fever Blisters/Herpes
Y N Sinus Problems   Y N Heart Murmur

Please provide more information if you answered yes to any of the above:
_____
_____
_____

Are you allergic to any of the following?

Y N Aspirin   Y N Dental Anesthetics Y N Penicillin
Y N Any Metals/Plastics Y N Erythromycin   Y N Tetracycline
Y N Codeine   Y N Latex   Y N Nickel

Please list other drugs/materials that you are allergic to: _____
_____

Have you ever taken a Bisphosphonate? (Also known as Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa) ☐ Yes ☐ No

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin)
☐ Yes ☐ No

Have you ever suffered from an eating disorder? ☐ Yes ☐ No
If Yes, Explain: _____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____
_____

Date of last dental cleaning: _____
                              Month   Year
Pending Dental Work: _____

Previous Orthodontic Evaluation? ☐ Yes ☐ No
Orthodontist's Name: _____
City & State: _____
Date: _____

Have you ever had orthodontic treatment? ☐ Yes ☐ No
Orthodontist's Name: _____
City & State: _____
Treatment Dates: _____

Have you ever had serious/difficult problems associated with dental work? ☐ Yes ☐ No
Please provide more information if you answered yes above:
_____
_____

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No
If yes, explain: _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No
If No, explain: _____

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems?_____

Habits: ☐ Thumb   ☐ Finger   ☐ Tongue

Explain: _____

Do you generally breathe through your mouth? ☐ Yes ☐ No
☐ While Awake   ☐ While Asleep   ☐ Unsure

Do you have any missing/extra permanent teeth? ☐ Yes ☐ No
Explain: _____

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

I authorize Socal Dental Specialists to perform orthodontic examination and obtain diagnostic records. Further, I understand that where appropriate, a credit card report will be obtained for the purpose of financing treatment.

_____   _____   _____
Print Patient's Name   Signature of Patient or Legal Guardian   Date

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Emergency Contact Name of nearest relative *not* living with you _____

Complete Address: _____

Phone_____   Relationship to Patient: _____