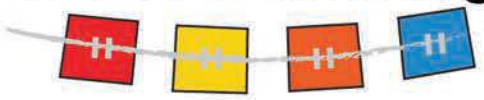
Braces & Invisalign



in Orange County

PATIENT INFORMATION

Today's Date: _____

Name _____ Birthdate: _____ Age _____
Address: _____
Tel #: _____ Social Security #: _____
Email: _____
Hobbies (Sports, Dance, Music, Acting, Skating, Instruments, Outdoor Activities):
_____
What do you like about your smile? _____
What don't you like about your smile? _____
Is there a specific problem or reason for your visit today? _____
Who may we thank for referring you to our office? _____

Occupation: _____ Employer: _____
Work Tel. #: _____
Does your occupation require public speaking? Y N May we contact you at work? Y N

SPOUSE INFORMATION (If Applicable)

Spouse's Name: _____ Birthdate: _____
Occupation: _____ Employer: _____
Social Security #: _____ Work Tel. #: _____

DENTAL INSURANCE INFORMATION

Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Tel. #: _____ Group Number: _____
Person Insured: ___ Yourself ___ Spouse (Other): _____
Person Responsible for Account: _____

MEDICAL AND DENTAL HISTORY

Dentist: _____ City: _____
Tel. #: _____ Last Visit to the Dentist: _____

Physician: _____ City: _____
Tel. #: _____

Have you had any major illness, surgery, medical problems? ___ Yes ___ No
List (if applicable)

_____

List any medications you are currently taking: _____
List any medications you are allergic to: _____
List any other allergies (latex gloves, metals, etc.):_____
Are you currently in good health? ___ Yes ___ No
Do you require antibiotics prior to having routine dental treatment? ___ Yes ___ No

For Women: Are you taking birth control pills? ___Yes ___ No
Are you pregnant? ___ Yes ___ No

Have you ever had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	HIV+/AIDS
Y N	Diabetes	Y N	Kidney / Liver Problems
Y N	Blood Transfusion	Y N	Tuberculosis (TB)
Y N	Hepatitis	Y N	Asthma
Y N	Rheumatic / Scarlet Fever	Y N	Bone Disorders
Y N	Heart Defect / Murmur	Y N	Nervous Disorders
Y N	Cancer	Y N	Epilepsy / Convulsions

Have there been any injuries to your face, mouth, teeth, or chin? ___ Yes ___ No
Are you aware of any missing or extra permanent teeth? ___ Yes ___ No
Have you had any jaw joint (TMJ) symptoms or problems? ___ Yes ___ No
Have you had any previous orthodontic treatment? ___ Yes ___ No

Are you aware of any of the following conditions?

Y N	Grinding / Clenching Teeth	Y N	Bleeding Gums
Y N	Abnormal Wear of Teeth	Y N	Unusual (excess) Tarter Buildup
Y N	Speech Problems	Y N	Lip Sucking / Biting

_____ _____

Patient's Signature Date