

ADULT PATIENT INFORMATION

Date _____

Patient's name _____
Last First MiddleResidence _____
Street City ZipMailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work phone _____

Previous Address (If less than 3 years) _____

Cell Phone _____ Birthdate _____ Social Security # _____

Email Address _____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced__

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

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

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature _____

Updates (date & initial) _____

Name _____ Date _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

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

Yes No Are you taking any medication? List: _____

Yes No Are you allergic to any medication? List: _____

Yes No Do you have a history of a major illness? _____

Yes No Have you ever smoked or chewed tobacco? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started? _____

Yes No Have you or are you taking any prescriptions for osteoporosis (Fosamax, Boniva, Actonel)? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Psychiatric Disorders |
| Anemia | Dizziness | Herpes | Radiation/Chemotherapy |
| Asthma or Hayfever | Epilepsy | High Blood Pressure | Rheumatic Fever |
| Bone Disorders | Heart Murmur | HIV / Aids | Tuberculosis |
| Congenital Heart Defect | Heart Problems | Nervous Disorders | Tumor or Cancer |

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

DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have your wisdom teeth been removed? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth, or teeth? _____

Yes No Do you have any type of thumb or tongue habit? _____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No What is your attitude toward receiving orthodontic treatment? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Are you aware that some appointments will be during work hours? _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. In addition, I authorize Dr. Paul Sasaki and Dr. Jennifer Yau to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Dr. Signature: _____ Date: _____