PATIENT INFORMATION

Computer # ______________________________ Office: ______________ Today's Date: ________________

_____ MALE _____ FEMALE DENTIST: ____

FIRST: ____ LAST: _______________________________________

ADDRESS:____E MAIL: ____________________________________

CITY: ____STATE: ___________________ ZIP: _________________

PHONE:__________________________________ WORK: _____________CELL:_____________BIRTHDATE:__________

EXAM DATE: __________________________________ REFERRED BY: _______________________________________

INSURANCE/OTHER INFORMATION

Name of Insured: ____

Name of Employer: ___________________________________**Group #:** ______________________________________

Social Security # and / or Member ID#: ____

Delta/California or Delta – what state: ____

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

	NAME OF POLICY HOLDER	BIRTHDATE	INSURANCE COMPANY
1.	___________________________________	_______________________	_________________________
2.	___________________________________	_______________________	_________________________

DENTAL HISTORY & STATUS

When were you last seen by a dentist? ____

Yes ____ No ____ Are you taking any pills or medications for dental reasons?
Yes ____ No ____ Have there been any unusual reactions to dental medications?
Yes ____ No ____ Have you had trouble associated with dental treatment?
Yes ____ No ____ Have you seen a periodontist, endodontist, or oral surgeon?
Yes ____ No ____ Have you had previous orthodontic treatment or consultation? When? ___________
Yes ____ No ____ Has any member of your family had orthodontic treatment?
Yes ____ No ____ Have you had any teeth extracted? Why?

Yes ____ No ____ Have you ever injured or broken any teeth? When and what happened?

Yes ____ No ____ Have you ever injured the head or face? When and what happened?

Yes ____ No ____ Do you have any missing or extra teeth?
Yes ____ No ____ Do you have any problem with eating, chewing, or swallowing?
Yes ____ No ____ Do you have any dental or facial pain?
Yes ____ No ____ Do your jaw joints make noise or hurt when opening, closing, or chewing?
Yes No Do you habitually grind or clench teeth together?

Yes	____	No	____	Are you aware of any swellings or growths in the mouth or on your face?
Yes	____	No	____	Do you have any negative or resistant feelings about orthodontic treatment?
Yes	____	No	____	Are you especially concerned about orthodontic treatment?
Yes	____	No	____	Are you dissatisfied about the appearance of your teeth?
Yes	____	No	____	Are you specifically resistant to: ___ Braces ___ Headgear ___ Retainers
Yes	_____	No	_____	Is there any other information we should know?_______________________