DOPAZO ORTHODONTICS

Please complete this form and bring it to your new patient appointment.

WE LOOK FORWARD TO YOUR VISIT!

PATIENT INFORMATION

Patient's Name:	Preferred Name:	Today's Date:
SEX: ☐ Male ☐ Female		Date of Birth:
Social Security Number:		Age:
Home Address: City/State/ZIP		Home Phone: E-Mail:
Employer:		Work Phone:
Whom may we thank for referring you:		General Dentist:
Please list other family members treated here:		

SPOUSE INFORMATION

Spouse's name:	Date of Birth:
Home Address: (*if different from patient*)	Home Phone: E-Mail:
Social Security Number:	Occupation:
Employer:	Work Phone:

DENTAL/ALLERGY HISTORY

Date of last dental visit:	Purpose of last visit:
What are the main concerns that you would like orthodontics to accomplish?	
Have you been evaluated for orthodontic treatment before?	☐ Yes ☐No
Have you had any injuries to the face, mouth or chin?	☐ Yes ☐No
Have you been informed of any missing or extra permanent teeth?	☐ Yes ☐No
Have you had any pain/tenderness in his/her jaw joint (TMJ/TMD)?	☐ Yes ☐No
Have you had a serious/difficult problem associated with any previous dental work?	☐ Yes ☐No
Do you have any speech problems?	☐ Yes ☐No
Do you generally breathe through your mouth while sleeping?	☐ Yes ☐No
Do you generally breathe through your mouth while awake?	☐ Yes ☐No
Do your gums ever bleed?	☐ Yes ☐No
Do you smoke or use tobacco in any form?	☐ Yes ☐No
Do you like your smile?	☐ Yes ☐No
How would you describe your current dental health? ☐ Good ☐ Fair ☐ Poor	

Allergies:

Do you have any of the following allergies?

Aspirin	☐Yes	☐No	**Codeine**	☐Yes	☐No	**Dental Anesthetics**	☐Yes ☐No
Latex	☐Yes	☐No	**Metal**	☐Yes	☐No	**Erythromycin**	☐Yes ☐No
Penicillin	☐Yes	☐No				**Tetracycline**	☐Yes ☐No

Handicaps/Disabilities:

More IMPORTANT details need to be completed on the back of this form. Thank you!

For Office Use ONLY	**Patient I.D.#**

MEDICAL HISTORY

Patient's Physician:	Phone Number:	Date of Last Visit:
Emergency Contact:	Phone Number:	Relationship:

Medical Conditions:

Have you ever had any of these medical conditions?

Abnormal Bleeding	□Yes □No	Heart Disease	□Yes □No
ADD/ADHD	□Yes □No	Heart Murmur	□Yes □No
Anemia/Radiation Treatment	□Yes □No	Hemophilia	□Yes □No
Artificial Bone/Joint/Valves	□Yes □No	Hepatitis (□A □B □C)	□Yes □No
Arthritis	□Yes □No	High/Low Blood pressure	□Yes □No
Asthma	□Yes □No	Kidney/Liver Problems	□Yes □No
Cancer/Leukemia	□Yes □No	Measles/Mumps	□Yes □No
Cerebral Palsy	□Yes □No	Mitral Valve Prolapse	□Yes □No
Congenital Heart Defects	□Yes □No	Mononucleosis	□Yes □No
Diabetes	□Yes □No	Pregnant (currently)	□Yes □No
Drug/Alcohol Abuse	□Yes □No	Psychiatric Problems	□Yes □No
Fever Blisters	□Yes □No	Rheumatic/Scarlet Fever	□Yes □No
Hearing Impairment	□Yes □No	Thyroid Disease	□Yes □No
Heart Attack/Problems	□Yes □No	Tuberculosis (TB)	□Yes □No

Please discuss any medical problems you have had:

Please list any current medications being used and the reason for each:

Are you currently taking or have you **EVER** taken medications to prevent bone loss/osteoporosis (i.e. Actonel, Fosamax, Boniva, intravenous bisphosphonates)? □Yes □No

RESPONSIBLE PARTY INFORMATION – *complete only if different from patient*

Person Financially Responsible:	Date of Birth:
Relationship to Patient	Social Security Number:
Billing Address:	Home Phone: E-Mail:
Employer:	Work Phone:

INSURANCE INFORMATATION

Do you have orthodontic coverage? □Yes □No		Employer:	
Insurance Company:		Insured's Name:	
Insurance Claims Address:		Insured's Date of Birth:	
		I.D. #	Group #
Insurance Company Phone:		Social Security # (required):	

Financial Information Signature Requirement

If this office accepts insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and/or deductibles that my insurance does not cover.

Signature of Patient/Responsible Party Date

This office reserves the right to verify credit of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of Patient/Responsible Party Date

Treatment Authorization Signature Requirement

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my status. I authorize the dental staff to perform and necessary dental services I may need during diagnostic and treatment.

Signature of Patient/Responsible Party Date

For Office use ONLY

I Verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments:

Doctor's Initial: Date: