Sethi Smiles
Orthodontics

Today's Date: _____

PATIENT INFORMATION – ADULT

Patient's Name _____ Title ☐Mrs. ☐Ms. ☐Mr. ☐Dr.

Date of Birth _____ Age _____ Sex ☐Male ☐Female Preferred Name _____

How did you hear about our office? _____

Relatives or friends previously treated here? _____

Address _____

Cell Phone Number _____ Email _____

Social Security # _____

I am: ☐Married ☐Divorced ☐Separated ☐Single ☐Widowed **Please fill the information below for Spouse/Other:**

Spouse / Other Name _____ Relationship to Patient _____

Date of Birth _____ Social Security # _____

If anyone else besides you is Financially Responsible for your treatment, Name? _____

DENTAL INSURANCE INFORMATION

Dental Insurance Coverage? ☐Yes ☐No Orthodontic Insurance Coverage? ☐Yes ☐No ☐Unsure

Insured's Name _____ Insured's Date of Birth _____

Insured's Social Security # _____ Insured's ID # _____

Insurance Company _____ Group # _____

Employer _____ Occupation _____

Do you have dual coverage? ☐Yes ☐No **If yes, please fill the information below for the second insurance**:

Insured's Name _____ Insured's Date of Birth _____

Insured's Social Security # _____ Insured's ID # _____

Insurance Company _____ Group # _____

Employer _____ Occupation _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Relationship to Patient _____

Address _____

Cell Phone _____ Email _____

Orthodontics is a service that provides an improvement in the appearance of the teeth (esthetics), in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate part of the body and may or may not respond well to treatment. If good oral hygiene is not practiced, problems such as tooth decay, enlarged and inflamed gums, and permanent marks on the teeth can result. Different amounts of risk exist in any medical or dental procedure, for example in orthodontics symptoms such as joint discomfort and root shortening are observed in a small percentage of cases. Whether or not there is any orthodontic treatment, teeth still may change and shift throughout our lifetime, and there can be some movement of teeth and some changes after treatment is over.

I have read and understand the above paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have read and understand the questions on this form and have accurately and truthfully answered all the above questions. I will not hold the doctor or any other staff member responsible for any errors or omissions that I have made in completing this form. I agree to inform this office of any changes in the patient's medical or dental history. In addition, I authorize the doctor to perform a complete orthodontic exam and take any diagnostic records (photos/x-rays) if necessary.

_____	_____	_____
Signature	**Print Name**	**Date**

MEDICAL HISTORY

Physician Name: _____ Date of Last Visit: _____

Address:_____ Phone: _____

Please mark (Yes) or (No) for the following questions about the Patient (If Yes, Please Fill in Details):

☐ Yes ☐ No Currently taking any **medication**? List and reason for taking: _____

☐ Yes ☐ No Ever taken a **bisphosphonate**? (Fosamax, Boniva, Actonel, Zometa, Aredia, other) _____

☐ Yes ☐ No Need any **Pre-Medication** for Dental Procedures? _____

☐ Yes ☐ No **Allergy** to any medication or Local Anesthetics (Novocaine or Lidocaine)? _____

☐ Yes ☐ No **Allergy** to anything else? (Metals/**Nickel**, **Latex**, Acrylic, plastic etc.) _____

☐ Yes ☐ No History of a major illness?_____

☐ Yes ☐ No Had any surgeries? Please explain: _____

☐ Yes ☐ No Ever been involved in a serious accident or had Bone Fractures?_____

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

☐ Yes ☐ No Smoke, vape, chew or use any tobacco or marijuana products? _____

Female Patients Only:

☐ Yes ☐ No Is the patient pregnant? Expected Due Date? _____

Please mark any of the Medical Conditions below that the Patient has had in the past or currently has:

☐ Abnormal Bleeding/Hemophilia
☐ ADD/ADHD
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Blood Pressure Problems (High or Low)
☐ Bone Disorders (Osteo- porosis or penia)
☐ Cancer
☐ Diabetes
☐ Dizziness/Fainting
☐ Drug/Alcohol Abuse
☐ Endocrine Problems
☐ Epilepsy/Convulsions
☐ Family History of Underbite
☐ Gastrointestinal Disorders
☐ Headaches
☐ Heart Defect (Congenital)
☐ Heart Disease
☐ Hepatitis/Liver Problems
☐ Herpes
☐ HIV/AIDS
☐ Jaw Pain/TMJ Disorder
☐ Kidney Disorders
☐ Mental Disorders (Anxiety, Depression)
☐ Nervous System/Neurological Disorders
☐ Pneumonia
☐ Radiation/Chemotherapy
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Seasonal Allergies/Hay Fever
☐ Tuberculosis
☐ Venereal Diseases

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

_____

DENTAL HISTORY

General Dentist or Pediatric Dentist Name: _____ Date of Last Visit: _____

Address:_____ Phone: _____

What concerns you most about your teeth? _____

Any preferred orthodontic option? ☐ Metal Braces ☐ Esthetic Metal Braces ☐ Clear Aligners (ex: Invisalign) ☐ No Preference

How soon do you want to get started? ☐ ASAP ☐ Within Weeks ☐ Within Months ☐ You tell me, Doc!

Is the Patient … or Has the Patient …

☐ Yes ☐ No Sensitive or self-conscious about his/her teeth?_____

☐ Yes ☐ No Excited to start orthodontic treatment? If not, why not? _____

☐ Yes ☐ No Ever seen an orthodontist before? Who and when?_____

☐ Yes ☐ No Had anyone in the family received orthodontic treatment? Who?_____

☐ Yes ☐ No Currently in any dental pain? _____

☐ Yes ☐ No Currently seeing another dental specialist? Who and why? _____

☐ Yes ☐ No Ever experienced any unfavorable reaction to dentistry or specific treatment? _____

☐ Yes ☐ No Ever lost, chipped, or damaged any teeth?_____

☐ Yes ☐ No Had any teeth extracted previously (baby teeth, extra teeth etc.)_____

☐ Yes ☐ No Ever had any injuries to face, mouth, or teeth?_____

☐ Yes ☐ No Extra sensitive (to temperature or pressure) in any part of his/her mouth? _____

☐ Yes ☐ No Noticed gum bleeding when brushing?_____

☐ Yes ☐ No Ever had any type of thumb/finger sucking or tongue thrusting habit? _____

☐ Yes ☐ No Ever had mouth breathing habit, snoring, or difficulty breathing?_____

☐ Yes ☐ No Ever had or needed Speech Therapy? When?_____

☐ Yes ☐ No Experienced jaw clicking, popping, or TMJ pain? _____

☐ Yes ☐ No Ever had teeth or jaws ever feel uncomfortable first thing in the morning? _____

☐ Yes ☐ No Aware of clenching or grinding teeth?_____

☐ Yes ☐ No Experienced “tension” headaches or chronic ringing in the ears (tinnitus)? _____

☐ Yes ☐ No In need of extra help with instructions?_____

☐ Yes ☐ No **Are you aware that some appointments will be during school/work hours?** _____