MILPITAS
ORTHODONTICS

WELCOME TO OUR OFFICE

We will strive to give you a beautiful smile and a functional bite that will last a lifetime. Please complete this form in full before your orthodontic examination. Please note that without sufficient information, a payment plan will not be extended in our office.

GENERAL INFORMATION:

Patient: _____ Preferred first name: _____ Birthdate: _____

Home address: _____ Sex: _____
Street City Zip

Cell Phone/Carrier: _____ Email address: _____ Marital Status: _____

Who may we thank for referring you? _____

What is your primary concern about your teeth? _____

How would you like your teeth straightened? _____

Why did you select Milpitas Orthodontics for your consultation? _____

EMPLOYMENT AND INSURANCE:

Employer: _____ Occupation: _____

Work phone: _____ Social Security # _____

Insurance Co: _____ Group #: _____
(If you have **Delta Dental**, please note which state the plan runs through)

Insurance Co. phone: _____ Insurance Co. address: _____

DUEL COVERAGE:

Your Spouse: _____ Birth Date: _____ Social Security # _____

Employer: _____ Occupation: _____ Work phone: _____

Insurance Co: _____ Group #: _____
(If you have **Delta Dental**, please note which state the plan runs through)

Insurance Co. phone: _____ Insurance Co. address: _____

MEDICAL HISTORY:

Please check yes or no by the name of any of the following which you have had or have currently:

YES	NO		YES	NO		YES	NO		YES	NO	
❑	❑	Hypertension (High blood pressure)	❑	❑	Diabetes	❑	❑	Fainting Spells/Seizures	❑	❑	Anemia
❑	❑	Excessive or Prolonged Bleeding	❑	❑	Arthritis	❑	❑	Pregnancy	❑	❑	Hemophilia
❑	❑	HIV (AIDS related complex)	❑	❑	Jaundice	❑	❑	Thyroid Disorder	❑	❑	Blood Transfusion
❑	❑	Kidney Disease	❑	❑	Endocrine Disorder	❑	❑	Asthma	❑	❑	Hepatitis
❑	❑	Heart Murmur	❑	❑	Venereal Disease	❑	❑	Headaches	❑	❑	Epilepsy
❑	❑	Rheumatic Heart Disease/Rheumatic Fever	❑	❑	Angina/Chest Pain	❑	❑	Rapid Weight Loss	❑	❑	Cerebral Palsy
❑	❑	Emotional or Nervous Disorder	❑	❑	Bone Disorder	❑	❑	Heart Trouble (Coronary)	❑	❑	Major Surgery
❑	❑	Clicking or Popping of Jaw	❑	❑	Injury to Face/Head	❑	❑	TMJ or Pain in Jaw Joints	❑	❑	Herpes

❑ ❑ Fear of the Dentist or Dental Procedures (if yes, please describe): _____

❑ ❑ Allergies (if yes, please specify): _____

Physician: _____ City: _____ Phone: _____
(first and last name)

Is there anything of importance in your medical history that has not been asked? Please explain: _____

_____

Please list all medications you are currently taking: _____

_____

Name of nearest relative NOT living with you: _____ Phone: _____

ORAL HEALTH:

Dentist: _____ City: _____
(first and last name)

Phone: _____ Last visit: _____

Other orthodontic consultations: _____ When: _____ Where: _____

Previous orthodontic treatment: _____

Previous periodontal disease: _____

I have provided the most current and up to date information. If I have omitted anything from this form, I have done so intentionally and I am thereby waiving Milpitas Orthodontics of all liability. I understand that where appropriate, credit bureau reports may be obtained. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also give my permission for Milpitas Orthodontics to share and/or consult with other doctors or insurance companies about my dental problems. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that I am financially responsible for payment in full of all accounts and amounts not covered by insurance.

Signed: _____ Date: _____

Reviewed by Milpitas Orthodontics: Doctor's Initials _____ Date _____