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 Name: _____ Preferred First Name: _____
First Last

Birth Date: _____ Sex: _____ School: _____ Grade: _____

Mailing Address: _____
Street City Zip

Email (for appointment reminders): _____ Preferred Phone #: _____ home / work/ mobile

Special Interests, Sports, and Hobbies: _____

Who may we thank for referring you: _____

ABOUT YOU:

RESPONSIBLE PARTY #1:

Name: _____ Birth Date: _____ Relationship to Patient: _____

Best Phone #: _____ home / work/ mobile Employer: _____ Occupation: _____

Insurance Co: _____ Member/Subscriber ID or Social Security Number: _____ Group #: _____

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

RESPONSIBLE PARTY #2:

Name: _____ Birth Date: _____ Relationship to Patient: _____

Best Phone #: _____ home / work/ mobile Employer: _____ Occupation: _____

Insurance Co: _____ Member/Subscriber ID or Social Security Number: _____ Group #: _____

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

Marital Status of Primary Responsible Party: Single ____ Married ____ Divorced ____ Widowed ____ Separated ____ Remarried ____

IN CASE OF A MEDICAL EMERGENCY IN OUR OFFICE:

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

Best person to contact, should all parents be unreachable: _____

Phone: _____ Relationship to patient: _____

MEDICAL HISTORY:

Please check yes or no by the name of any of the following which your child had or has currently:

	YES	NO		YES	NO
Liver problems or Hepatitis	❑	❑	Major Surgery	❑	❑
Malignancies, Leukemia or Radiation	❑	❑	Tonsillitis	❑	❑
Any heart ailments	❑	❑	Physical or Mental Handicaps	❑	❑
Excessive bleeding from cuts or extractions	❑	❑	Cerebral Palsy	❑	❑
Blood transfusion(s)	❑	❑	Psychiatric care or emotional problems	❑	❑
Anemia or other blood problems	❑	❑	Extreme nervousness or apprehension	❑	❑
Ulcers	❑	❑	Depression or anxiety	❑	❑
Colitis or Kidney problems	❑	❑	ADHD or Autism	❑	❑
Epilepsy	❑	❑	Aspergers or Autism	❑	❑
Rhuematic Fever	❑	❑	Allergies or sensitivity to any medications	❑	❑
Thyroid problems	❑	❑	Asthma or other breathing problems	❑	❑
Diabetes	❑	❑	Sinus problems or hay-fever	❑	❑
High risk group for AIDS	❑	❑	Frequent headaches	❑	❑

If you marked **yes** to any of the above questions, please elaborate if necessary: _____

Please list any allergies: _____

Please list all medications your child is currently taking: _____

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

_____

The following questions are necessary to determine the amount of remaining physical growth:

Father's height: _____ Mother's height: _____ Rate of growth appears to be: slow _____ average _____ fast _____

Female patients: Has the menstrual cycle started? _____ At what age? _____

DENTAL HISTORY:

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

Please check yes or no by the name of any of the following which your child had or has currently:

	YES	NO		YES	NO
Fear of dental procedures	❑	❑	Bleeding gums	❑	❑
Traumatic injury to mouth or teeth	❑	❑	Frequent blisters on lips and mouth	❑	❑
Tooth sensitivity to cold, heat, sweets, or pressure	❑	❑	Mouth breathing	❑	❑
Clicking or grinding in the jaw joint	❑	❑	Swelling or lumps in the mouth	❑	❑
Pain or tenderness around the ear	❑	❑	Missing or additional teeth	❑	❑
Limited movement or soreness of jaw joint	❑	❑	Musical instrument that touches lips	❑	❑

Oral habits: Thumb sucking _____ Fingernail biting _____ Cheek biting _____ Clenching or grinding of teeth: Daytime _____ Nighttime _____

Frequency of brushing _____ Frequency of flossing _____ Texture of tooth brush*: soft medium firm electric*

Describe any other dental factors not listed: _____

What do you feel is wrong with patient's teeth or bite: _____

What would you like to have orthodontic treatment to accomplish: _____

Does patient want his/her teeth straightened: _____

Has patient had other orthodontic treatment: _____ Consultations: _____ Name of Orthodontist: _____

Have patients or siblings had orthodontic treatment: _____ Name of Orthodontist: _____

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 child's medical status. I also give my permission for Milpitas Orthodontics to share and/or consult with other doctors or insurance companies about my child's 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 _____