PATIENT INFORMATION - FOR PATIENTS UNDER 18 YEARS OF AGE

DIAZ ORTHODONTICS

Date_____

Patient's name _____
Last First Middle

Nickname_____ Birth Date_____

Address_____
Street City State Zip

Home phone (_____) _____ Cell phone (_____) _____ E-mail _____

Preferred Language: English_____ Spanish_____ Portuguese_____ Other_____

School _____ Sports/Hobbies _____

Whom may we thank for referring you to our office? _____

Dentist____ Family member____ Friend____ Other_____ (Google, Yahoo, Yelp, Website, Social Media, Healthgrades, American Association of Orthodontists, American Board of Orthodontics)

PARENTS INFORMATION

Mother's name_____ Birth Date _____
Last First Middle

Address_____
Street City State Zip

Home phone (_____) _____ Cell phone (_____) _____ E-mail address _____

Employer_____ Occupation_____ Work Phone (_____)_____

Father's name_____ Birth Date _____
Last First Middle

Address_____
Street City State Zip

Home phone (_____) _____ Cell phone (_____) _____ E-mail address _____

Employer_____ Occupation_____ Work Phone (_____)_____

Parents marital status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Primary contact: Mother ____ Father ____ Billing Party ____

BILLING PARTY INFORMATION

Name _____
Last First Middle

Address_____
Street City State Zip

Home phone (_____) _____ Cell phone (_____) _____ E-mail address _____

Employer_____ Occupation_____ Work Phone (_____)_____

DENTAL INSURANCE INFORMATION

Insurance Co. Name _____ Insurance phone number (_____) _____

Insurance Co. Address_____
Street City State Zip

Policy owner's name _____ Policy owner's birth date _____

Policy ID or SSN_____ Group No _____ Policy owner's relationship to patient_____

Do you expect your insurance to change within the next 6 to 12 months? Yes ___ No ___

MEDICAL HISTORY

Mark any of the medical conditions below that the patient has had or currently has:

Yes___ No___ Abnormal bleeding
Yes___ No___ ADD / ADHD
Yes___ No___ Anemia
Yes___ No___ Arthritis
Yes___ No___ Asthma
Yes___ No___ Artificial Bone / Joints
Yes___ No___ Artificial Heart Valve
Yes___ No___ Cancer
Yes___ No___ Chemotherapy
Yes___ No___ Congenital Heart Defect
Yes___ No___ Diabetes
Yes___ No___ Difficulty Breathing
Yes___ No___ Epilepsy
Yes___ No___ Gastrointestinal Disorder
Yes___ No___ Handicap / Disabilities
Yes___ No___ Hearing Impairment
Yes___ No___ Heart problems / Surgery
Yes___ No___ Heart Murmur
Yes___ No___ Hepatitis
Yes___ No___ High Blood Pressure
Yes___ No___ HIV / AIDS
Yes___ No___ Hospitalization
Yes___ No___ Kidney / Liver problems
Yes___ No___ Lupus
Yes___ No___ Mitral Valve Prolapse
Yes___ No___ Psychiatric problems
Yes___ No___ Radiation Therapy
Yes___ No___ Rheumatic / Scarlet Fever
Yes___ No___ Seizures
Yes___ No___ Sinus Problems
Yes___ No___ Stroke
Yes___ No___ Thyroid Problems
Yes___ No___ Tuberculosis (TB)
Yes___ No___ Venereal Disease
Yes___ No___ Allergies _____

If you marked YES for any of the above, please explain: _____

_____

Has the patient had any disease, surgery, or medical condition not listed above?_____

Please list all the medications that you take:_____

_____

Are you allergic to any of the following:

☐ Medications: _____

☐ Acrylic ☐ Codeine ☐ Latex ☐ Penicillin
☐ Aspirin ☐ Dental Anesthetics ☐ Metal ☐ Plastic

DENTAL HISTORY

Yes___ No___ Injuries to face / teeth
Yes___ No___ Uncomfortable dental experience
Yes___ No___ Missing teeth
Yes___ No___ Extra teeth
Yes___ No___ Thumb / Finger sucking
Yes___ No___ Tongue Thrusting
Yes___ No___ Clenching or Grinding teeth
Yes___ No___ Pain/Noises in the joint (TMJ)
Yes___ No___ Mouth Breathing
Yes___ No___ Periodontal disease / Gum bleeding
Yes___ No___ Root resorption
Yes___ No___ Speech problems
Yes___ No___ Other orthodontics treatment
Yes___ No___ Do you like your smile?

Date of patient's last dental visit: _____

Name and phone number of patient's dentist: _____ (_____)_____
Name Phone Number

I understand that the information that I have given today is correct to the best of my knowledge. 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 status. I authorize the dental staff to perform any necessary dental services for my son/daughter during diagnostics and treatment with my informed consent.

_____ _____
Signature Date

OFFICE USE ONLY

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

Doctor's comments_____ Initials_____ Date_____