DIAZ ORTHODONTICS

ADULT PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Birth Date_____

Marital status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Residence _____
Street City State Zip

Mailing address_____
Street City State Zip

Cell phone (____) _____ Home phone (____) _____ Work phone (____) _____

E-mail address_____

Employer_____ Occupation_____ No years employed_____

Preferred Language: English_____ Spanish_____ Portuguese_____ Other_____

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)

SPOUSE'S INFORMATION

Spouse's name_____
Last First Middle

Employer_____ Occupation_____ No years employed_____

Birth Date_____ Cell phone (____) _____ 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 during diagnostics and treatment with my informed consent.

_____ _____
Signature Date

OFFICE USE ONLY

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

Doctor's comments_____ Initials_____ Date_____