Abay Orthodontics

CONFIDENTIAL

ABOUT YOU

Today's Date: ____ / ____ / ____

Title: MR. ☐ MRS. ☐ DR. ☐ MS. ☐

Name: _____
(Last) (First) (M.I.)

I prefer to be called: _____ Male ☐ Female ☐

Birth Date: _____ Age: ____ SSN#: _____

Home Address: _____

_____

City _____ State _____ Zip _____

Single Widowed Separated Married Divorced

Home Phone: _____

Work Phone: _____ Ext: _____

Employer: _____

Employer Address: _____

How long there: _____

Occupation: _____

Who may we thank for referring you? _____

General Dentist: _____

Last Visit Date: _____

SPOUSE INFORMATION

His or Her Name: _____

Employer: _____

Work Phone: _____ Ext: _____

SSN#: _____

Birth Date: ____ / ____ / ____

EMERGENCY CONTACT

In the event of emergency, is there someone who lives near you that we should contact?

Name: _____
(Last) (First) (M.I.)

Relation: _____

Home Phone: _____

Work Phone: _____ Ext: _____

ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage? Yes ☐ No ☐

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group#: _____

SSN#: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthday: _____

Policy Owner's Employer: _____

Secondary

Orthodontic Coverage? Yes ☐ No ☐

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group#: _____

SSN#: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthday: _____

Policy Owner's Employer: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
(Last) (First) (M.I.)

Home Phone: _____

Work Phone: _____ Ext: _____

Billing Address: _____

_____
(City) (State) (Zip)

Relation: _____ SSN# _____

Employer: _____

DL#: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and ADA.

MEDICAL HISTORY

Do you have a personal physician? Yes ☐ No ☐

Physician's Name: _____

Phone Number: _____

Date of Last Visit: _____

Your current physical health is: Good ☐ Fair ☐ Poor ☐

Are you currently under the care of physician? Y ☐ N ☐

Taking any prescriptions/over the counter drugs? Y ☐ N ☐

If yes, please list each one: _____

_____

For Women: Taking birth control pills? Y ☐ N ☐

Are you pregnant? Y ☐ N ☐

If yes, how many weeks along? _____

Are you nursing? Y ☐ N ☐

Have you ever had the following?

Anemia/Radiation Treatment	Y	N	Hemophilia/Abnormal bleeding	Y	N
Artificial bones/joints	Y	N			
Artificial valves	Y	N	Hepatitis	Y	N
Blood Transfusion	Y	N	High/Low Blood pressure	Y	N
Cancer/Chemotherapy	Y	N	HIV +/AIDS	Y	N
Congenital Heart Defect	Y	N	Hospitalized for any reason	Y	N
Diabetes/Tuberculosis (TB)	Y	N	Kidney Problem	Y	N
Difficulty Breathing	Y	N	Mitral valve prolapse	Y	N
Drugs/Alcohol abuse	Y	N	Psychiatric problem	Y	N
Emphysema/Glaucoma	Y	N	Rheumatic/Scarlet fever	Y	N
Epilepsy/Seizure/Fainting Spells	Y	N	Severe/frequent headache	Y	N
Fever Blister/Herpes	Y	N	Shingles	Y	N
Heart Attack/Stroke	Y	N	Sinus Problem	Y	N
Heart Murmur	Y	N	Ulcer/Colitis	Y	N
Heart Surgery/Pacemaker	Y	N	Venereal Disease	Y	N

Are you allergic to any following?

Aspirin			Tetracycline	Y N
Dental Anesthetics			Codeine	Y N
Penicillin			Latex	Y N
Any Metal/Plastic			Other _____	

Please list any serious medical condition(s) that you have ever had: _____

_____

_____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____

_____

Have you ever had or been evaluated for orthodontic treatment? Y ☐ N ☐

Have you ever had serious / difficult problem associated with any previous dental work? Y ☐ N ☐

Do you now or have you experienced pain or discomfort in your jaw joint (TMJ/TMD) ? Y ☐ N ☐

Your current dental health is: Good ☐ Fair ☐ Poor ☐

Do you like your smile? Y ☐ N ☐

Do your gums ever bleed? Y ☐ N ☐

Have you ever had injury to: Mouth ☐ Teeth ☐ Chin ☐

Do you have speech problems? Y ☐ N ☐

If yes, please explain: _____

Do you generally breathe through your mouth? Y ☐ N ☐

If yes, while you are awake? Y ☐ N ☐

Or while you are asleep? Y ☐ N ☐

Do you have missing or extra permanent teeth? Y ☐ N ☐

I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need during diagnosis and treatment with my informed consent.

_____ / _____

(Signature) (Date)

I authorize my insurance company to pay Dr. Emeline Abay all insurance benefits otherwise payable to me for service rendered. I authorized the use of this signature on all insurance forms. I authorize Dr. Emeline Abay to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

_____ / _____

(Signature) (Date)

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

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

Doctor's Comments: _____ Initials _____ Date: _____

_____