Patient Information

Date _____

Patients name _____ Soc. Sec. # _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age_____ Sex_____

Patient Work Phone _____ If a minor, give parent or guardian's name _____

Email Address _____ Whom may we thank for referring you? _____

General Dentist _____ Physician _____

Reason for consultation _____

Have you ever been examined by an orthodontist? _____ If yes, When? _____ Had Braces? _____

Medical Information

Are you in good health? Yes _____ No _____ Does patient have any history of major illness? Yes _____ No _____

Have you ever been under the care of a physician for illness? Yes _____ No _____

If yes, give reason _____

Check any of the following for which the you have been treated or diagnosed with:

Heart complications	☐	Emphysema	☐	Hepatitis B (Serum)	☐	A.I.D.S	☐
Tuberculosis	☐	Thyroid Problem	☐ .	H.I.V Positive	☐	Diabetes	☐
High Blood Pressure	☐	Pneumonia	☐	Bond Disorders	☐	Herpes/Cold Sores	☐
Low Blood Pressure	☐	Asthma	☐	Blood Transfusion	☐	Anemia	☐
Rheumatic Fever	☐	Latex Sensitivity	☐	Hemophilia/Prolonged	☐	Hypoglycemia	☐
Arthritis / Rheumatism	☐	Allergies	☐	Bleeding		Nervous/Anxious	☐
Kidney Complications	☐	Sinus Trouble	☐	Epilepsy or Seizures	☐	Venereal Disease	☐
Neurological Disorders	☐	Periodontal Disease	☐	Fainting or Dizzy Spells	☐		
Ulcers	☐	Cancer	☐	Liver Involvement	☐		
Hepatitis A (Infectious)	☐	Psychiatric/Psychological Care	☐	Endocrine Problems	☐		

Do you take any bisphosphonate medications for osteoporosis, such as Fosamax? _____

Do you have a tendency to colds? ☐ Yes ☐ No Sore Throats? ☐ Yes ☐ No Ear Infections? Yes ☐ No ☐

Have tonsils and/or adenoids been removed? ☐ Yes ☐ NO At what age? _____

List any drugs or medications now being taken and give reasons _____

List any allergies or drug sensitivity _____

Dental History

Have you had any injuries to the face, mouth or teeth? ☐ Yes ☐ No

Habits:		
	Mouth Breathing	☐ Yes ☐ No
	Nail/Lip Biting	☐ Yes ☐ No
	Grinding or Clenching of Teeth	☐ Yes ☐ No
	Tongue Thrusting	☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Financially Responsible Party Information

☐ Ms. ☐ Miss ☐ Married ☐ Separated
Name ☐ Mrs. ☐ Mr. ☐ Dr. _____ ☐ Single ☐ Divorced
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone_____

Insurance Information

Do you have orthodontic coverage? ☐ Yes ☐ No Benefit amount: _____ If no, please skip this section.

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____ Group No. _____ Local No._____

Insurance Company Name and Address _____

Insurance Company Phone Number _____

Secondary insurance? ☐ Yes ☐ No Benefit amount: _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____ Group No. _____ Local No._____

Insurance Company Name and Address _____

Insurance Company Phone Number _____

Emergency Information

Name of nearest relative not living not with you _____

Complete Address _____ Phone _____

Authorization and Release

Please Sign And Initial ➡

_____ In accordance with HIPPA regulations, I hereby give my permission for the office of Dr. Sepideh Ariarad to use patient records and information for diagnosis, treatment planning, education, and insurance purposes.

_____ I authorize the dentist to release any information including the diagnosis, and records for treatment rendered to me or my child if necessary for insurance purposes. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated.

Signature (Parent's signature if minor) _____