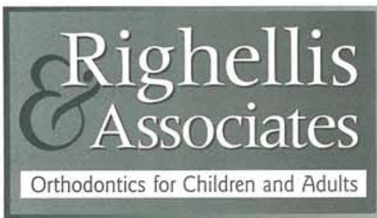


Village Square at Montclair
2220 Mountain Blvd
Oakland, CA 94611
Phone: 510-482-0600
Fax: 510-482-4710

WELCOME!

Please take a few minutes to complete the following information so we can better care for your orthodontic needs.

PATIENT AND FAMILY INFORMATION

Patient's Name ______ Birthdate ______ ☐ Male ☐ Female
Home Address ______
City ______ State ______ Zip ______ Home Phone ______
School ______ Grade ______
Sister (ages) ______ Brother (ages) ______

PARENTS / GUARDIANS

Name ______
Relationship ______
Address ______
City ______ State ______ Zip ______
Occupation ______
Employer ______
Business Phone ______

Name ______
Relationship ______
Address ______
City ______ State ______ Zip ______
Occupation ______
Employer ______
Business Phone ______

Does the patient live with both parents? ______ If no, please elaborate ______
Is the patient adopted? ______
Has any other member of the family been a patient at this office? Names: ______
Whom may we thank for referring you? ______
In case of emergency, who should we contact? ______ Phone ______

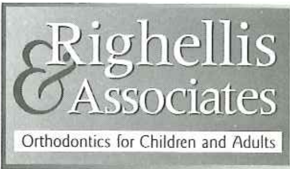
PRIMARY DENTAL INSURANCE

Person Responsible for Account (Last, First, Initial) ______
Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______
Address ______
City ______ State ______ Zip ______ Home Phone ______
Responsible Party Employed By ______ Business Phone ______
Business Address ______ Occupation ______
Insurance Company ______ (800) Phone # ______
Insurance Company Address ______
Subscriber I.D. # ______ Group # ______

ADDITIONAL DENTAL INSURANCE

Insured Name (Last, First, Initial) ______
Relationship to Patient ______ Birthdate ______ Soc. Sec. # ______
Address ______
City ______ State ______ Zip ______ Home Phone ______
Insured Employed By ______ Business Phone ______
Insurance Company ______ (800) Phone # ______
Insurance Company Address ______
Subscriber I.D. # ______ Group # ______

(See Reverse Side)



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Name ______________________ Date ______________________

Please answer the following questions for the patient.

Update ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of last visit ______________________

Is the patient currently under medical treatment? ____________ Any allergies, including nickel or latex? ____________

Is the patient taking any medications? ________ If so which medications ______________________

Has the patient had any serious illness and/or operations? ______________________

Has the patient had any allergic reactions to drugs or medications? ________ If so which drugs/medications ____________

Please write yes in the box for each medical condition that applies:

☐ ADD	☐ AIDS/HIV	☐ anemia	☐ arthritis/rheumatism
☐ artificial heart valves	☐ asthma/hayfever	☐ bleeding problems	☐ blood disease
☐ bone disorders	☐ cancer	☐ diabetes	☐ emotional problems
☐ epilepsy	☐ fainting/dizzy spells	☐ frequent headaches	☐ frequent colds/flu
☐ heart problems	☐ hepatitis-type ☐	☐ herpes	☐ high/low blood pressure
☐ kidney disease	☐ liver disease	☐ motor difficulties	☐ nervous problems
☐ pneumonia	☐ radiation treatment	☐ sinus problems	☐ stroke
☐ thyroid problems	☐ Tourette's	☐ tonsils/adenoids . . . if removed, age ________	
☐ tuberculosis	☐ other ______________________		

DENTAL HISTORY

Family Dentist ______________________ Date of last visit ____________ Date of last complete full mouth x-rays ____________

Please write yes in box for all that apply:

☐ bleeding gums ☐ blisters on lips/mouth ☐ prone to cavities

☐ any missing teeth ☐ any extra teeth ☐ any teeth extracted

☐ any chewing difficulties ☐ any speech difficulties . . . if so explain ______________________

☐ Do you clench or grind your teeth? ☐ Any severe head and/or facial injuries? If so explain ______________________

☐ Do you have pain or clicking upon opening/closing your mouth? ☐ Has your jaw ever locked open or closed?

☐ Fingernail/cheek or lip biting ☐ History of thumb/finger biting/sucking

☐ Do you have difficulty breathing through your nose?

☐ Have you ever consulted with an orthodontist? If so when ______________________

☐ Have you ever had orthodontic treatment? If so when ______________________

☐ Would you mind wearing braces to straighten your teeth?

What about your teeth/bite would you like to correct? ______________________

What concerns you most about wearing braces?

☐ appearance ☐ cost ☐ length of time ☐ pain ☐ effectiveness ☐ other ______________________

Thank you for your cooperation. Your signature ______________________

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

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the Orthodontist and dental staff to perform the necessary dental/orthodontic services I may need.

Signature ______________________ Date ______________________

(See Reverse Side)