



Village Square at Montclair
2220 Mountain Blvd. #204
Oakland, California 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 INFORMATION

Patient's Name _____ Birthdate _____ Male Female
 Home Address _____
 City _____ State _____ Zip _____ Home Phone _____
 Occupation _____
 Employer _____
 Business Address _____
 Business Phone _____
 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

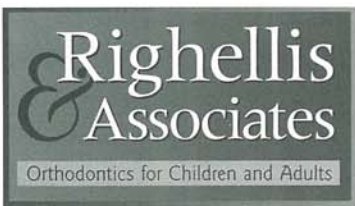
Person Responsible for Account (Last, First, Initial) _____
 Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
 Address _____
 City _____ State _____ Zip _____ Home Phone _____
 Responsible Party Employed By _____ Business Phone _____
 Business Address _____ Occupation _____
 Insurance 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 # _____

ADULT

(See Reverse Side)



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Name _____ Date _____
 Update _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Are you currently under medical treatment? _____ Are you taking any medications? _____

Have you ever had any serious illness and/or operations? _____

Have you had any allergic reactions to drugs or medications? _____ If so which drugs/medications _____

Any allergies to nickel or latex? _____ (Women only) Are you pregnant? _____

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

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> anemia | <input type="checkbox"/> arthritis/rheumatism | <input type="checkbox"/> artificial heart valves |
| <input type="checkbox"/> asthma/hayfever | <input type="checkbox"/> bleeding problems | <input type="checkbox"/> blood disease | <input type="checkbox"/> bone disorders |
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> emotional problems | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> fainting/dizzy spells | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> heart problems |
| <input type="checkbox"/> hepatitis-type <input type="checkbox"/> | <input type="checkbox"/> herpes | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> liver disease | <input type="checkbox"/> nervous problems | <input type="checkbox"/> pneumonia | <input type="checkbox"/> radiation treatment |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid problems | |
| <input type="checkbox"/> tonsils/adenoids . . . if removed, age _____ | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other _____ | |

DENTAL HISTORY

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

Please write yes in the box for all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> bleeding gums | <input type="checkbox"/> blisters on lips/mouth | <input type="checkbox"/> prone to cavities |
| <input type="checkbox"/> any missing teeth | <input type="checkbox"/> any extra teeth | <input type="checkbox"/> any teeth extracted |
| <input type="checkbox"/> chewing difficulties | <input type="checkbox"/> speech difficulties . . . if so explain _____ | |
| <input type="checkbox"/> Do you clench or grind your teeth? | <input type="checkbox"/> Any severe head and/or facial injuries? If so explain _____ | |
| <input type="checkbox"/> Do you have pain or clicking upon opening/closing your mouth? | <input type="checkbox"/> Has your jaw ever locked open or closed? | |
| <input type="checkbox"/> Fingernail/cheek or lip biting | <input type="checkbox"/> History of thumb/finger biting/sucking | |
| <input type="checkbox"/> Do you have difficulty breathing through your nose? | | |
| <input type="checkbox"/> Have you ever consulted with an orthodontist? If so when _____ | | |
| <input type="checkbox"/> Have you ever had orthodontic treatment? If so when _____ | | |
| <input type="checkbox"/> Would you mind wearing braces to straighten your teeth? | | |

What would you like orthodontic treatment to accomplish? _____

What concerns you most about wearing braces?

- appearance cost length of time pain effectiveness other _____

Thank you for your cooperation.

Your signature _____

ADULT

(See Reverse Side)