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 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, whom 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)

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

Name ______________________ **Date** ______________________

Email ______________________ **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 check **yes or no** in **all** boxes below:

yes	no		yes	no		yes	no		yes	no	
☐	☐	AIDS/HIV	☐	☐	anemia	☐	☐	arthritis/rheumatism	☐	☐	artificial heart valves
☐	☐	asthma	☐	☐	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	☐	☐	nervous problems	☐	☐	pneumonia	☐	☐	radiation treatment
☐	☐	sinus problems	☐	☐	stroke	☐	☐	thyroid problems	☐	☐	hayfever
☐	☐	tonsils/adenoids . . . if removed, age ________				☐	☐	tuberculosis	☐	☐	other ________

DENTAL HISTORY

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

Please check **yes or no** in **all** boxes below:

yes	no		yes	no		yes	no	
☐	☐	bleeding gums	☐	☐	blisters on lips/mouth	☐	☐	prone to cavities
☐	☐	any missing teeth	☐	☐	any extra teeth	☐	☐	any teeth extracted
☐	☐	chewing difficulties	☐	☐	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 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.

Our office is HIPAA 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 ______________________