LAGUNA NIGUEL ORTHODONTICS & CHILDREN'S DENTISTRY

Patient Information

Date_____

Patient's name _____ Male _____Female _____
First **Middle** **Last** **Nickname**

Address _____
Street City Zip
Home Phone _____ Date of Birth _____ Age _____ Social Security #_____

If patient is a minor, please provide name(s) of parent(s)/guardian(s) _____

Whom may we thank for referring you to our office? _____

School_____ Grade _____

Children/Sibling: Name(s) _____Date(s) of Birth _____ Age(s) _____

Please list some hobbies or interests _____

Responsible Party Information

Self/Parent/Guardian name _____
First Middle Last

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Marital Status: Single___ Married___ Divorced___ Widowed ___

Spouse/Parent/Guardian/Other_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Person Financially responsible for this account: Self__ Spouse___ Parent___ Guardian___ Other _____

Dental Insurance Information

(If Dental and/or Orthodontic Coverage, Please provide card)

Insured's Name _____ Date of Birth _____ Social Security # _____
Employer _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes complete the following:

Insured's Name_____ Date of Birth _____ Insured's Social Security # _____
Employer _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Emergency Contact (nearest you) _____ Relationship to Patient _____

Address _____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details):

Yes No Is the patient in good health? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations or hospitalization? _____
Yes No Ever been involved in a serious accident? _____
Yes No Is the patient allergic to any medication? _____
Yes No Any history of smoking or chewing tobacco? _____
Yes No Any allergy to any medication or substance (including latex or metals)?
Yes No Any tonsils or adenoids been removed?

Female Patients Only:

Yes No Are you Pregnant? _____
Yes No Are you nursing? _____

Children only:

Yes No Has the patient reached puberty? _____
Yes No Has the patient's menstruation begun (girls)? _____
Yes No Has the patient's voice changed (boys)? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

DENTAL HISTORY

General Dentist _____ Phone Number _____
Date of most recent dental exam/cleaning/x-rays _____
What are the main concerns that you would like Orthodontics to address?? _____

Yes No Has the patient ever been evaluated by an orthodontist? If yes, who and when? _____
Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have the patient ever been informed of any missing or extra teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of patient's mouth sensitive to temperature? Where? _____
Yes No Is any part of patient's mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Is the patient aware of any jaw joint clicking or popping (TMJ/TMD)? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Do teeth or jaws ever feel uncomfortable when the patient awakes in the morning? _____
Yes No Any type of thumb or tongue habit? _____

Yes No Is the patient a mouth breather? _____
Yes No Does patient have any speech problems? _____
Yes No Has anyone in the family received orthodontic treatment? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No If the patient is under age 18, height of parents? Mom___ Dad____
Yes No Are you aware that some appointments will be during school hours? _____

BENEFITS

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. In the event of a default on agreed upon payment arrangements, I am responsible for reasonable collection costs.

I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Bahar Movahed to perform a complete orthodontic evaluation.

Signature (Parent/Responsible party if minor): _____ Date:_____
Doctor's signature (verbal review of medical information): _____ Date: _____