SALAITA
ORTHODONTICS
PURSUING EXCELLENCE

PATIENT INFORMATION

Patient Name:_____
LAST FIRST MI

Gender: Male ☐ Female ☐

Birthdate:_____/_____/_____ Age:_____

Home Address:_____

_____
CITY STATE ZIP

Primary Phone Number: _____

Email:_____

Occupation:_____

Employer:_____

Marital Status: S ☐ M ☐ D ☐ W ☐ SO ☐

SPOUSE/PARTNER INFORMATION

Spouse/Partner Name:_____
LAST FIRST MI

Address (If different than patient):_____

_____
CITY STATE ZIP

Primary Phone Number:_____

Occupation:_____

Employer:_____

RESPONSIBLE PARTY FOR ACCOUNT

Name:_____
LAST FIRST MI

Relationship to Patient:_____

Address: _____

_____
CITY STATE ZIP

Phone Number:_____

Social Security Number:_____/_____/_____

Birthdate:_____/_____/_____

PRIMARY DENTAL INSURANCE

Insurance Co. Name:_____

Insurance Co. Address: _____

_____
CITY STATE ZIP

Insurance Co. Phone:_____

Group #:_____

Member ID #:_____

Policy Holders Name:_____

Relationship to Patient:_____

Policy Holders SSN:_____/_____/_____

Policy Holders Birthdate:_____/_____/_____

Employer:_____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:_____

Insurance Co. Address: _____

_____
CITY STATE ZIP

Insurance Co. Phone:_____

Group #:_____

Member ID #:_____

Policy Holders Name:_____

Relationship to Patient:_____

Policy Holders SSN:_____/_____/_____

Policy Holders Birthdate:_____/_____/_____

Employer:_____

(PLEASE COMPLETE BACK OF FORM)

SALAITA ORTHODONTICS

PURSUING EXCELLENCE

DENTAL HISTORY

General Dentist:_____ Phone:_____

What was the date of your last visit:_____/_____/_____

How did you hear about our practice? Advertisement ☐ Internet ☐ Family/Friend ☐ Dentist ☐ Other ☐

Whom may we thank for referring you (if applicable)? _____

What are the main concerns that you would like orthodontics to correct?_____

Do you like your smile? Yes ☐ No ☐

Have you visited an orthodontist before? Yes ☐ No ☐If yes, date/reason:_____

Have we treated other family members? If yes, please list their names:_____

Have Tonsils ☐ Adenoids ☐ been removed?

Do you or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) Yes ☐ No ☐

If yes, please describe left/right or both. AM or PM:_____

Do you have any missing or extra permanent teeth? Yes ☐ No ☐

Have you ever had injury to the following: (Select all that apply) Teeth ☐ Jaw ☐ Chin ☐

Please describe injury:_____

Do you currently or have you ever had any of the following habits: (Check all that apply)

Clenching/Grinding teeth: ☐ Lip Sucking/Biting: ☐ Thumb/Finger Sucking: ☐ Mouth Breathing: ☐

Tongue Thrusting: ☐ Nail Biting: ☐ Chewing/Eating Problem: ☐

Do your gums bleed? Yes ☐ No ☐ Do you use tobacco products? Yes ☐ No ☐

MEDICAL HISTORY

Are you currently under a physician's care? Yes ☐ No ☐ If yes, explain:_____

Family Physician:_____ Phone:_____

What was the date of your last visit:_____/_____/_____

Do you have any allergies or sensitivities? (ie medication, latex, nickel, etc) Yes ☐ No ☐ If yes, explain:_____

Are you taking any medications at this time? Yes ☐ No ☐ If yes, explain:_____

Have you ever had a blood transfusion? Yes ☐ No ☐ If yes, explain:_____

WOMEN

Are you pregnant? Yes ☐ No ☐ Are you nursing? Yes ☐ No ☐ Are you taking birth control? Yes ☐ No ☐

Please check if you ever had any of the following:

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Coughing Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other

AUTHORIZATION - PLEASE SIGN & DATE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my dental treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Signature:_____ Date:_____