San Martín ORTHODONTICS

Welcome to San Martín Orthodontics. Please fill out this form as best as you can.

ABOUT YOU

Name: _____
Mr. / Mrs. / Ms. / Miss / Dr.

Preferred name: _____
SS#: ____ - ____ - _____ [ ] male [ ] female
Date of Birth: _____ / _____ / _____ Age: _____
Email: _____
[ ] Single [ ] Married [ ] Divorced
[ ] Widowed [ ] Separated

Home address: _____
_____
city state zip

Home #: _____
Cell #: _____
Work #: _____ Ext: _____
Best time to reach you: _____
Drivers License #: _____ State: _____
Employer: _____
Employer's address: _____
How long there: _____ Occupation: _____

How did you hear about us? _____
_____
General dentist: _____
Last visit: _____

ABOUT YOUR SPOUSE

His/Her name: _____
Employer: _____
Phone #: _____ Date of Birth: _____

INSURANCE

PRIMARY
Orthodontic coverage: [ ] yes [ ] no
Dental coverage: [ ] yes [ ] no

Insurance company: _____
Address: _____
_____
Phone: (_____) _____ - _____
Group # (Plan, local or policy #): _____
Insured's Name: _____
Relation: _____
Insured's DOB: _____ / _____ / _____
Insured's SS#: ____ - ____ - _____
Insured's Employer: _____

SECONDARY
Orthodontic coverage: [ ] yes [ ] no
Dental coverage: [ ] yes [ ] no

Insurance company: _____
Address: _____
_____
Phone: (_____) _____ - _____
Group # (Plan, local or policy #): _____
Insured's Name: _____
Relation: _____
Insured's DOB: _____ / _____ / _____
Insured's SS#: ____ - ____ - _____
Insured's Employer: _____

EMERGENCY CONTACT

Name: _____
Phone #: _____
Relation: _____

Medical History

Do you have a personal physician: [ ] yes [ ] no
Physician's name: _____
Phone #: _____ Last visit: _____

Your current health is: [ ] good [ ] fair [ ] poor
Are you currently under the care of a physician?
[ ] yes [ ] no
Please explain: _____
Are you taking any prescription or OTC drugs?
[ ] yes [ ] no
Please list: _____

For Women:

Are you taking birth control pills? [ ] yes [ ] no
Are you pregnant? [ ] yes [ ] no
Are you nursing? [ ] yes [ ] no

Have you ever had any of the following diseases or medical problems?

Yes	No	
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Heart surgery / pacemaker
[ ]	[ ]	Artificial bones / joints / valves
[ ]	[ ]	Asthma / Arthritis
[ ]	[ ]	Blood transfusion
[ ]	[ ]	Cancer / Chemotherapy
[ ]	[ ]	Congenital heart defect
[ ]	[ ]	Diabetes / Tuberculosis (TB)
[ ]	[ ]	Difficulty Breathing
[ ]	[ ]	Drug / Alcohol abuse
[ ]	[ ]	Emphysema / Glaucoma
[ ]	[ ]	Epilepsy / Seizures / Fainting
[ ]	[ ]	Fever blisters / Herpes
[ ]	[ ]	Heart attack / Stroke
[ ]	[ ]	Heart Murmur
[ ]	[ ]	Hemophilia
[ ]	[ ]	Hepatitis
[ ]	[ ]	High / Low blood pressure
[ ]	[ ]	HIV+ / AIDS
[ ]	[ ]	Hospitalizations for any reason
[ ]	[ ]	Kidney problems
[ ]	[ ]	Mitral valve prolapse
[ ]	[ ]	Psychiatric problems
[ ]	[ ]	Rheumatic / Scarlet fever
[ ]	[ ]	Severe / Frequent headaches
[ ]	[ ]	Shingles
[ ]	[ ]	Sinus problems
[ ]	[ ]	Ulcers / Colitis
[ ]	[ ]	Venereal disease

Please list any serious medical conditions that you have ever had: _____

Allergies

Are you allergic to any of the following?

Yes	No	
[ ]	[ ]	Aspirin
[ ]	[ ]	Latex
[ ]	[ ]	Codeine
[ ]	[ ]	Dental anesthetics
[ ]	[ ]	Erythromycin
[ ]	[ ]	Penicillin
[ ]	[ ]	Tetracycline
[ ]	[ ]	Any metals or plastics: _____
[ ]	[ ]	Other _____

Dental History

What is the main reason why you are seeking orthodontic treatment? _____

_____

Have you or anyone in your family ever had JAW SURGERY?_____

Have you ever been evaluated for braces? _____
Have you ever had a problem with any previous dental work? _____
Do you now or have you ever experienced pain in your jaw joint (TMJ/TMD)? _____

Your dental health is: [ ] good [ ] fair [ ] poor
Do your gums bleed? [ ] yes [ ] no
Any injury to the mouth/jaw? [ ] yes [ ] no
Do you have speech problems? [ ] yes [ ] no
Do you generally breathe through their mouth:
while awake? [ ] yes [ ] no
while asleep? [ ] yes [ ] no
Any missing or extra teeth? [ ] yes [ ] no

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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date