WELCOME

We would like to welcome you to our office. We will strive to give you a beautiful smile and a functional bite that will last a lifetime. Please complete this form before your orthodontic examination.

Patient

Patient's Last Name________________________ First Name__________________________________ MI_______
Title Mr. Mrs. Ms. Miss Dr. Other_________ I prefer to be called ______________________________
Birth date_____________________ Sex: Male Female Social Security Number _________-_________-________
Marital Status (Circle): Single Married Separated Divorced Widowed
Home Address____________________________________ City, State, Zip Code____________________________
Phone Number (____) _______-__________ (Home, Cell, or Work) Alternate Number (_____) ______-_________
E-mail Address(es): ____
Occupation_________________________________ Employer ____

Patient's Dentist___________________________ Address, City, State_____________________________________
Last Seen ____________ Phone Number (_____)______-_____________ E-mail____________________________
Physician________________________________ Phone Number (_____)______-__________ Last Seen ________

General Information

What concerns you about your teeth?____
Whom may we thank for referring you?____
Have you had previous orthodontic treatment? Please explain ____

Dental Insurance

Primary policy holder's full name______________________________________ Birthdate____________________
Social Security #________-________-________ Relationship to patient___________________________________
Address and phone ____
Employer_____________________________ Address____
Insurance Co__________________________ Group #_____________________ Id#_________________________

Secondary policy holder's full name______________________________________Birthdate__________________
Social Security #________-________-________ Relationship to patient___________________________________
Address and phone ____
Employer_____________________________ Address____
Insurance Co__________________________ Group #_____________________ Id#_________________________

Medical History- Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. Please mark yes or no.

 yes no Hypertension yes no Diabetes yes no Faiting Spells-Seizures yes no Pain in Jaw Joints yes no Arthritis
 yes no Excessive bleeding yes no Pregnancy yes no Thyroid Disorder yes no Hepatitis or Jaundice yes no Allergies
 yes no Blood Transfusion yes no Asthma yes no Kidney disease yes no Injury to face or head yes no TMJ
 yes no HIV virus yes no Hemophilia yes no Heart murmur yes no Venereal Disease yes no Headaches
 yes no Heart Disease yes no Epilepsy yes no Theumatic Fever yes no Major Surgery yes no Angina
 yes no Clicking of Jaw yes no Herpes yes no Rapid Weight Loss yes no Cerebral Palsy yes no Anemia
 yes no Endocrine Disorder yes no Night Sweats yes no Bone Disorder yes no Emotional/Nervous disorder

Is there anything of importance in your medical history that has not been asked? Please explain. __________________________
____

Patient Health Information

List any medication, nutritional supplements, herbal medication or non-prescription medication that you take.

Medication ____ Taken for_____________________________________
Medication ____ Taken for_____________________________________
Medication ____ Taken for_____________________________________

Closest Relative

Spouse or closest relative's name(s) ____
Title Mr. Mrs. Ms. Miss Dr. Other__________ Relationship to patient ___________________________
Address ____ Phone number (______) ______-________________

Release & Waiver

I have read the above questions and understand them. I will not hold Dr. Ashouri or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify Dr. Ashouri of any changes in my medical or dental health. I also give my permission for Dr. Ashouri to share and or consult with other doctor's or insurance company's information about my dental problems. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that I am financially responsible for payment in full of all accounts and amounts not covered by insurance.

Patient Signature ____ Date___________________

Doctor' Signature ____ Date___________________