CAMINO REAL
ORTHODONTICS

ABOUT YOU

Today's Date ____ /____ /_____

Name _____
First Middle Last (Nickname)

Birth Date ____ /____ /_____ Social Security # _____ ☐ Male ☐ Female

Home # ( ) _____ Work #: ( ) _____ Ext. _____ Cell # ( ) _____

Home Address _____

_____
City State Zip

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer _____

How long there? _____ Occupation _____

Who may we Thank for referring you? _____

Other family members seen by us _____ Previous/Present General Dentist: _____

Dentist # ( ) _____ Last Visit Date ____ /____ /_____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # ( ) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name

_____
First Middle Last

Relationship to Patient _____

Policy Owner's Birthdate _____/_____/_____

SS# _____

Policy Owner's Employer _____

Orthodontic Coverage? ☐ Yes ☐ No

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # ( ) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name

_____
First Middle Last

Relationship to Patient _____

Policy Owner's Birthdate _____/_____/_____

SS# _____

Policy Owner's Employer _____

Orthodontic Coverage? ☐ Yes ☐ No

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MEDICAL HISTORY

Physician's Name _____

Physician's # ( ) _____ Last Visit Date _____

Are you currently under the care of a physician? ☐ Yes ☐ No if so explain _____

Your current health is ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you taking any prescription, over-the-counter, or herbal supplement drugs? ☐ Yes ☐ No

If so please list each one _____

For Women: Are you pregnant? ☐ Yes ☐ No Are you anticipating becoming pregnant? ☐ Yes ☐ No

Now or in the past, have you had:

Y N Abnormal Bleeding
Y N AIDS or HIV +
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bone/ Joint/ Valves
Y N Asthma/Hay Fever/Sinus Trouble/Hives
Y N Blood Transfusion
Y N Cancer/Chemotherapy/Tumor/Radiation
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Attack/ Surgery
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High/Low Blood Pressure
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Osteoporosis
Y N Pacemaker
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Stroke
Y N Thyroid Problem
Y N Tonsil or Adenoid Conditions
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Allergies or reactions to any of the following:

Y N Local Anesthetics (Novocaine or Lidocaine)
Y N Aspirin
Y N Ibuprofen (Motrin, Advil)
Y N Penicillin or other antibiotics
Y N Sulfa Drugs
Y N Codeine or other narcotics
Y N Metals (jewelry, clothing snaps)
Y N Latex (gloves, balloons)
Y N Vinyl
Y N Acrylic
Y N Animals
Y N Food (Specify) ____
Y N Other substances (Specify)____

Now or in the past, have you had:

Y N Permanent or "extra" teeth removed
Y N Supernumerary or congenitally missing teeth
Y N Chipped/Injured primary or permanent teeth
Y N Teeth sensitive to hot/cold; teeth throb/ache
Y N Jaw fractures
Y N "Dead" teeth or root canals treated
Y N Periodontal "gum problems" or treatment
Y N "Gum Boils", frequent caner sores/cold sores
Y N Thumb, finger, or sucking habit-Till what age__
Y N Abnormal swallowing habit (tongue thrusting)
Y N Mouth/difficulty breathing habit, snoring
Y N Tooth grinding or jaw clenching
Y N Any pain/clicking/locking in jaw
Y N Any pain soreness in muscles around face/ear
Y N Difficulty in chewing or jaw opening
Y N Have you been treated for "TMD" or "TMJ"
Y N Aware of loose/broken/missing fillings
Y N Any teeth irritating cheek, lip, tongue or palate
Y N Any wisdom teeth problems
Y N Serious trouble associated with previous dental treatment
Y N Ever has a prior orthodontic examination or treatment

How often do you brush _____ floss _____ What is your primary concern _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have make in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice. I authorize the dental staff to perform the necessary dental services that I may need.

_____

Signature of parent or guardian Date