CAMINO REAL ORTHODONTICS

MICHAEL HASSEY • DDS
Diplomate, American Board of Orthodontics

About You

Today's Date: _____ E-mail Address: _____
Name: _____
Last First MI Mr Mrs Ms Dr
I prefer to be called: _____ ☐ Male ☐ Female
Birthdate: __/___/____ SS#: _____
Home Address: _____
_____
City State Zip
☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Hm#: (___)_____ Cell#: (___)_____
Wk#: (___)_____Ext: ____ DL#: _____
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: _____

Spouse Information

His/Her Name: _____
Employer: _____
Wk#: (___)_____Ext: ____ DL#: _____
Birthdate: __/___/____ SS#: _____

Person Responsible for Account: _____
Wk#: (___)_____Ext: __ Hm#: (___)_____
Billing Address: _____
_____
City State Zip
Relationship: _____ SS#: _____
Employer: _____ DL#: _____

Neighbor or Relative not living with you:
His/Her Name: _____ Relation: _____
Wk#: (___)_____Ext: __ Hm#: (___)_____
Address: _____
_____
City State Zip

Insurance

Primary 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 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

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:

☐ Yes ☐ No	Abnormal Bleeding
☐ Yes ☐ No	AIDS or HIV +
☐ Yes ☐ No	Alcohol/Drug Abuse
☐ Yes ☐ No	Anemia
☐ Yes ☐ No	Arthritis
☐ Yes ☐ No	Artificial Bone/ Joint/ Valves
☐ Yes ☐ No	Asthma/Hay Fever/Sinus Trouble/Hives
☐ Yes ☐ No	Blood Transfusion
☐ Yes ☐ No	Cancer/Chemotherapy/Tumor/Radiation
☐ Yes ☐ No	Colitis
☐ Yes ☐ No	Congenital Heart Defect
☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Difficulty Breathing
☐ Yes ☐ No	Emphysema
☐ Yes ☐ No	Epilepsy
☐ Yes ☐ No	Fainting Spells
☐ Yes ☐ No	Frequent Headaches
☐ Yes ☐ No	Glaucoma
☐ Yes ☐ No	Heart Attack/ Surgery
☐ Yes ☐ No	Heart Murmur
☐ Yes ☐ No	Hemophilia
☐ Yes ☐ No	Hepatitis
☐ Yes ☐ No	Herpes/Fever Blisters
☐ Yes ☐ No	High/Low Blood Pressure
☐ Yes ☐ No	Hospitalized for Any Reason
☐ Yes ☐ No	Kidney Problems
☐ Yes ☐ No	Liver Disease
☐ Yes ☐ No	Mitral Valve Prolapse
☐ Yes ☐ No	Osteoporosis
☐ Yes ☐ No	Pacemaker
☐ Yes ☐ No	Psychiatric Problems
☐ Yes ☐ No	Rheumatic/Scarlet Fever
☐ Yes ☐ No	Seizures
☐ Yes ☐ No	Stroke
☐ Yes ☐ No	Thyroid Problem
☐ Yes ☐ No	Tonsil or Adenoid Conditions
☐ Yes ☐ No	Tuberculosis (TB)
☐ Yes ☐ No	Ulcers
☐ Yes ☐ No	Venereal Disease

Allergies or reactions to any of the following:

☐ Yes ☐ No	Local Anesthetics (Novocaine or Lidocaine)
☐ Yes ☐ No	Aspirin
☐ Yes ☐ No	Ibuprofen (Motrin, Advil)
☐ Yes ☐ No	Penicillin or other antibiotics
☐ Yes ☐ No	Sulfa Drugs
☐ Yes ☐ No	Codeine or other narcotics
☐ Yes ☐ No	Metals (jewelry, clothing snaps)
☐ Yes ☐ No	Latex (gloves, balloons)
☐ Yes ☐ No	Vinyl
☐ Yes ☐ No	Acrylic
☐ Yes ☐ No	Animals
☐ Yes ☐ No	Food (Specify_____)
☐ Yes ☐ No	Other substances (Specify_____)

Now or in the past have you had:

☐ Yes ☐ No	Permanent or "extra" teeth removed
☐ Yes ☐ No	Supernumerary or congenitally missing teeth
☐ Yes ☐ No	Chipped/Injured primary or permanent teeth
☐ Yes ☐ No	Teeth sensitive to hot/cold; teeth throb/ache
☐ Yes ☐ No	Jaw fractures
☐ Yes ☐ No	"Dead" teeth or root canals treated
☐ Yes ☐ No	Periodontal "gum problems" or treatment
☐ Yes ☐ No	"Gum Boils", frequent caner sores/cold sores
☐ Yes ☐ No	Thumb, finger, or sucking habit-Till what age__
☐ Yes ☐ No	Abnormal swallowing habit (tongue thrusting)
☐ Yes ☐ No	Mouth/difficulty breathing habit, snoring
☐ Yes ☐ No	Tooth grinding or jaw clenching
☐ Yes ☐ No	Any pain/clicking/locking in jaw
☐ Yes ☐ No	Any pain soreness in muscles around face/ear
☐ Yes ☐ No	Difficulty in chewing or jaw opening
☐ Yes ☐ No	Have you been treated for "TMD" or "TMJ"
☐ Yes ☐ No	Aware of loose/broken/missing fillings
☐ Yes ☐ No	Any teeth irritating cheek, lip, tongue or palate
☐ Yes ☐ No	Any wisdom teeth problems
☐ Yes ☐ No	Serious trouble associated with previous dental treatment
☐ Yes ☐ No	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: _____ Date: _____
Patient