Calabasas

23622 Calabasas Road, #119
Calabasas, CA 91302

(http://pairorthodontics.com/)

ORTHODONTICS ACQUAINTANCE CARD

Date _____

Date of Birth: _____

Patient's Name: _____ Age: _____ Sex: _____

Residence Address: _____ Phone: _____ Cell: _____

City: _____ Zip: _____

Who may we thank for sending you to our office? _____

Occupation: _____

Employed By: _____ Bus. Phone: _____

Bus. Address: _____ Soc. Sec. No.: _____

Drivers License #: _____ Email Address: _____

Person responsible for account: _____

Spouse's Name: _____ DOB: _____ Cell: _____

Employed By: _____ Bus. Phone: _____

Bus. Address: _____ Soc. Sec. No.: _____

IF YOU HAVE ORTHODONTICS INSURANCE, PLEASE COMPLETE INFORMATION BELOW:

DENTAL INSURANCE COMPANY #1

Dental Ins. Co.: _____

Their phone #: _____

Group #: _____

Social Security or ID: _____

DENTAL INSURANCE COMPANY #2

Dental Ins. Co.: _____

Their phone #: _____

Group #: _____

Social Security or ID: _____

DENTAL/MEDICAL HISTORY

Have you had any of the following medical conditions or problems?

PLEASE CHECK:

◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Hemophillia	◯ Yes ◯ No	Cancer
◯ Yes ◯ No	Heart problems of any kind	◯ Yes ◯ No	Bledding problems	◯ Yes ◯ No	Diabetes
◯ Yes ◯ No	Convulsions / Epilepsy	◯ Yes ◯ No	Hearing impairment	◯ Yes ◯ No	HIV + / AIDS
◯ Yes ◯ No	Hyperactive	◯ Yes ◯ No	Any operations	◯ Yes ◯ No	Rheumatic fever
◯ Yes ◯ No	Any stays in hospital	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Hepatitis
				◯ Yes ◯ No	Latex Allergy

Are there any other medical conditions or problems? ◯ Yes ◯ No If yes, please list: _____

Are you currently under the care of a physician? ◯ Yes ◯ No

Patient's Physician: _____ City: _____ Phone #: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS ◯ Yes ◯ No If yes, please list: _____

Are you taking any prescription Medications? ◯ Yes ◯ No If yes, please list: _____

DO YOU NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT? ◯ Yes ◯ No

Patient's Dentist: _____ City: _____

Approximate date of last visit: _____

PLEASE CHECK:

Has there been any injuries to the face, mouth or teeth? ◯ Yes ◯ No

Do you have any speech problems? ◯ Yes ◯ No

Have you had tongue-thrust or speech therapy? ◯ Yes ◯ No

Have you ever been informed of any missing or extra teeth? ◯ Yes ◯ No

Have you ever been told you have TMJ (Temporomandibular Joint) problems? ◯ Yes ◯ No

Does your jaw joint ever make noise (cracking or popping sounds) when chewing or yawning? ◯ Yes ◯ No

Has your jaw ever locked open? ◯ Yes ◯ No

When was the last dental care? _____

Interests ie. Sports, hobbies, etc. _____

WHAT DO YOU WANT ORTHODONTICS TREATMENT TO ACCOMPLISH: _____

_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in strictest of confidence, and it is my responsibility to inform this office of any changes in my health status.

Date _____

Parent or Guardian's signature:

SUBMIT