

# Invisalign & Braces



in Orange County

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_

Tel #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Email: \_\_\_\_\_

Hobbies (Sports, Dance, Music, Acting, Skating, Instruments, Outdoor Activities):  
\_\_\_\_\_

What do you like about your smile? \_\_\_\_\_

What don't you like about your smile? \_\_\_\_\_

Is there a specific problem or reason for your visit today? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Tel. #: \_\_\_\_\_

Does your occupation require public speaking? Y N May we contact you at work? Y N

## **SPOUSE INFORMATION** (If Applicable)

Spouse's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Work Tel. #: \_\_\_\_\_

## **DENTAL INSURANCE INFORMATION**

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Tel. #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Person Insured: \_\_\_ Yourself \_\_\_ Spouse (Other): \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

## **MEDICAL AND DENTAL HISTORY**

Dentist: \_\_\_\_\_ City: \_\_\_\_\_

Tel. #: \_\_\_\_\_ Last Visit to the Dentist: \_\_\_\_\_

Physician: \_\_\_\_\_ City: \_\_\_\_\_

Tel. #: \_\_\_\_\_

Have you had any major illness, surgery, medical problems? \_\_\_ Yes \_\_\_ No  
List (if applicable)

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List any medications you are currently taking: \_\_\_\_\_

List any medications you are allergic to: \_\_\_\_\_

List any other allergies (latex gloves, metals, etc.): \_\_\_\_\_

Are you currently in good health? \_\_\_ Yes \_\_\_ No

Do you require antibiotics prior to having routine dental treatment? \_\_\_ Yes \_\_\_ No

For Women: Are you taking birth control pills? \_\_\_ Yes \_\_\_ No

Are you pregnant? \_\_\_ Yes \_\_\_ No

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding

Y N HIV+/AIDS

Y N Diabetes

Y N Kidney / Liver Problems

Y N Blood Transfusion

Y N Tuberculosis (TB)

Y N Hepatitis

Y N Asthma

Y N Rheumatic / Scarlet Fever

Y N Bone Disorders

Y N Heart Defect / Murmur

Y N Nervous Disorders

Y N Cancer

Y N Epilepsy / Convulsions

Have there been any injuries to your face, mouth, teeth, or chin? \_\_\_ Yes \_\_\_ No

Are you aware of any missing or extra permanent teeth? \_\_\_ Yes \_\_\_ No

Have you had any jaw joint (TMJ) symptoms or problems? \_\_\_ Yes \_\_\_ No

Have you had any previous orthodontic treatment? \_\_\_ Yes \_\_\_ No

Are you aware of any of the following conditions?

Y N Grinding / Clenching Teeth

Y N Bleeding Gums

Y N Abnormal Wear of Teeth

Y N Unusual (excess) Tarter Buildup

Y N Speech Problems

Y N Lip Sucking / Biting

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Patient's Signature

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Date