WELCOME!

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Hector Maldonado, DDS
Diplomate, American Board of Orthodontics

Today's Date _____

What concerns you about your or your child's teeth? _____

How did you hear about our office? _____

What is the best phone number to contact you regarding appointments? _____

INFORMATION ABOUT THE PATIENT:

Name _____ Nickname _____
First Middle Last

Address _____
Street City State Zip

Home Phone #: _____ Birthdate: _____ Sex: M / F

Cell Phone #: _____ Work Phone # (Adults): _____

E-mail (or parent's if minor): _____ Social Security #: _____

Patient's Dentist: _____ Last Visited: _____

Names of any other family members treated by Dr. Maldonado: _____

Who will be financially responsible for the patient's treatment? _____

What person not living with the patient should we contact in the event of an emergency?

Name _____ Phone #: _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION:

School: _____ Grade: _____

Mother's Name: _____ Social Security # _____
First MI Last

Address *(if different)*: _____

Phone #s: Home *(if different)* _____ Work _____ Cell _____

Birthdate _____ Employer _____

Father's Name: _____ Social Security # _____
First MI Last

Address *(if different)*: _____

Phone #s: Home *(if different)* _____ Work _____ Cell _____

Birthdate _____ Employer _____

Do you have dental insurance *with* orthodontic coverage? YES NO NOT SURE

If YES or NOT SURE, please complete this page.

If NO, skip to next page.

INSURANCE INFORMATION:

Policy Owner's Name: _____ Social Security #: _____

Policy Owner's Birthdate: _____ Relationship to Patient: _____

Policy Owner's Employer: _____

Employer Address: _____

Insurance Company: _____ Group #: _____

Insurance Co. Address: _____

Insurance Phone #: _____

SECONDARY INSURANCE INFORMATION:

Policy Owner's Name: _____ Social Security #: _____

Policy Owner's Birthdate: _____ Relationship to Patient: _____

Policy Owner's Employer: _____

Employer Address: _____

Insurance Company: _____ Group #: _____

Insurance Co. Address: _____

Insurance Phone #: _____

MEDICAL HISTORY

Please check **YES** if the **PATIENT** either currently has or has had in the past any of the following:

Yes	No	
O	O	Anemia
O	O	Hepatitis (liver disease)
O	O	Kidney problems
O	O	AIDS/HIV
O	O	Venereal disease
O	O	Rheumatic fever
O	O	Heart disease
O	O	Heart murmur
O	O	Stroke
O	O	Tuberculosis
O	O	Diabetes
O	O	Endocrine problems
O	O	Bone disorders
O	O	Epilepsy
O	O	Abnormal bleeding
O	O	Cleft lip/cleft palate

DENTAL HISTORY

Yes	No	
O	O	Tonsils removed
O	O	Adenoids removed
O	O	Asthma
O	O	Difficulty breathing through nose
O	O	Snoring/Mouth breathing
O	O	Allergies
O	O	High/Low blood pressure
O	O	Neurological problems
O	O	Radiation treatment
O	O	Cancer/Leukemia
O	O	Speech problems
O	O	Bisphosphonate drugs for osteoporosis
O	O	Any operations or hospital stays? Reason: _____

Yes	No	
O	O	Injuries to teeth
O	O	Injuries to face
O	O	Thumb/finger sucking
O	O	Biting nails or objects
O	O	Missing or extra teeth
O	O	Clench/grind teeth
O	O	Jaw pops when chewing
O	O	Pain around jaw joint
O	O	Frequent headaches
O	O	Gum surgery
O	O	Root canal(s)
O	O	TMJ treatment
O	O	Wore braces previously
O	O	Evaluated for braces before
O	O	Smokes or smokeless tobacco
O	O	Problems with previous dental treatment

Describe any current medical treatment the patient is undergoing (other than routine check-ups) or any other medical conditions that you feel we should be aware of:

_____

_____

If being treated for a medical condition, what is your physician's name? _____
Physician's Phone #: _____

Please list any medication the patient is currently taking and the reason for doing so:

_____

_____

Please list all drugs/things that the patient is allergic to:

_____

FOR ADOLESCENT FEMALE PATIENTS ONLY:
Has the patient had her first menstrual cycle? YES NO
If YES, at what age did it start? _____

FOR ADULT FEMALE PATIENTS ONLY:
Are you currently pregnant? YES NO

SIGNATURE:

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in this information. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature (Parent/Guardian's signature if the patient is a minor)

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and/or patient named herein.

Initials: _____ Date: _____

Comments: _____

_____

_____