Date_____

Caldwell – Ontario Orthodontics

Neal P. Webster, D.D.S.

CONFIDENTIAL PATIENT INFORMATION

Name: (First)_____(M.I.)_____ (Last)_____Nickname or common name_____

Address_____City_____State_____Zip_____

Home phone #_____ Cell Phone #_____Daytime/Work phone #_____

Birthdate_____ Male Female Marital Status_____ SS#_____

If patient is a minor, give parent's or guardian's name_____

Family dentist_____ Whom may we thank for referring you to our office?_____

Patient's Spouse: (First,M.I. Last)_____Birthdate_____SS#_____

Spouse's Employer_____Spouse's Occupation_____No. of yrs. Employed_____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

E-mail address: _____

( ) **Patient is self responsible**: Patient's Employer_____ Occupation_____

Number of years employed_____ How long at current address?_____

Previous address if less than 3 yrs_____

If patient is a minor, please complete the following:

Patient's Father: Name (First, M.I., Last)_____Marital status_____

Address (if different from patient)_____City_____State_____Zip_____

How long at this address?_____If less than 3 yrs, previous address_____

Daytime/Work Phone_____ Home phone (if different)_____Cell Phone_____

Employer_____Occupation_____No. of yrs. employed_____

Social Security #_____Birthdate_____

Patient's Mother: Name (First, M.I., Last)_____Marital status_____

Address (if different from patient)_____City_____State_____Zip_____

How long at this address?_____If less than 3 yrs, previous address_____

Daytime/Work Phone_____Home phone (if different)_____Cell Phone_____

Employer_____Occupation_____No. of yrs. employed_____

Social Security #_____Birthdate_____

Patient's Step-father (If applicable) Name (First, M.I., Last)_____Marital Status_____

Address (if different from patient)_____City_____State_____Zip_____

How long at this address?_____If less than 3 yrs, previous address_____

Daytime/Work phone_____Home phone (if different)_____Cell Phone_____

Employer_____Occupation_____No. of yrs. employed_____

Social Security #_____Birthdate_____

Patient's Step-mother (If applicable) Name (First, M.I., Last)_____Marital status_____

Address (If different from patient)_____City_____State_____Zip_____

How long at this address?_____If less than 3 yrs, previous address_____

Daytime Phone_____Home phone (if different)_____Cell Phone_____

Employer_____Occupation_____No. of yrs. employed_____

Social Security #_____Birthdate_____

If patient is a child: Child lives with: (circle) Parents Mother Father Other_____

Names and ages of any other children in your family_____

MEDICAL HISTORY

Has patient had or currently have any of the following?

( ) Heart problems/Murmur
( ) High blood pressure
( ) Artificial heart valves or joints
( ) Diabetes
( ) Respiratory disease
( ) Headaches
( ) Hepatitus/ Liver disease
( ) Emotional disorders
( ) Tonsillitis
( ) AIDS
( ) Venereal disease
( ) Hemophilia (Bleeding disorders)
( ) Rheumatic fever
( ) Recent unexpected weight loss
( ) General allergies_____
( ) Allergies to Medicine_____
( ) Latex Allergy/Sensitivity

Is patient taking medicine at this time? ( ) Yes ( ) No If yes, what_____

Is patient on a special diet?_____ Is patient currently under physician's care ( ) Yes ( ) No

Other medical concerns_____

Has patient been advised by his/her physician to pre-medicate prior to dental work? ( ) Yes ( ) No

If patient is a child above 12 yrs. of age: (The following questions pertain to growth)

Girls: Has menstruation begun ( ) Yes Age_____ ( ) No

Boys: Has voice changed? ( ) Yes ( ) No

Has there been a recent growth spurt? ( ) Yes ( ) No

DENTAL HISTORY

Are you satisfied with the way your teeth look? Yes No Is patient self-conscious of his/her teeth? Yes No

Describe what you would like to see changed:_____

Are you having pain or discomfort at this time? Yes No Have you ever experienced any unfavorable dental treatment? Yes No

Do you feel nervous about having dental treatment? Yes No Do your gums bleed when brushing? Yes No

Has patient had:

( ) Recent dental check-up ( ) Peridontal treatment ( ) Impressions
( ) Teeth cleaned recently ( ) Recent fillings, crowns ( ) Fluoride treatment
( ) Recent dental x-rays ( ) Trauma to face/mouth ( ) TMJ splint
( ) Previous orthodontic consultation_____

Have any other family members had orthodontic treatment? Yes_____ No

Have any family members been previous patients of Dr. Sakimoto or Dr. Webster? Yes--Names_____ No

Does patient have past/present history of:

( ) Tongue Thrust ( ) Mouth breathing
( ) Thumb sucking ( ) Speech impediment
( ) Finger sucking ( ) TMJ symptoms_____
( ) Nail biting ( ) Popping, Clicking in jaw joint – if yes ( ) occasionally ( ) constantly

DENTAL INSURANCE INFORMATION

Primary ( )

Insured's Name_____Insured Social Security #_____

Insurance Co._____Group #_____ID #_____

Insurance Co. Address_____

Phone #_____

Insured's Employer_____Insured's Birthdate_____

Do you have dual coverage? Yes No If yes:

Secondary ( )

Insured's Name_____Insured Social Security #_____

Insurance Co._____Group #_____ID#_____

Insurance Co. Address_____

Phone #_____

Insured's Employer_____Insured's Birthdate_____

EMERGENCY INFORMATION

Name of emergency contact person not living with you_____

Address_____City_____Zip_____

Phone_____ Relationship_____

Authorization

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits, and I assign directly all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services I/my child may need

Signature of Patient or Parent or Guardian

_____Date_____

Updates (Initial and date)

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____