San Diego Orthodontic Specialists
16766 Bernardo Center Dr # 203
San Diego, California, 92128
858-487-8900
www.smiles4sd.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:

Best places and times to contact you:	Send appointment reminders via: ❑ Text Message ❑ Email ❑ Mail

Please tell us where you heard about us (check all that apply):

❑ Friend or Relative (name): ❑ Newspaper Ad ❑ Radio Ad ❑ TV Ad
❑ Ad in Mail ❑ Saw our Office ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website:
❑ Other:

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

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Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy):	Relationship to Patient:	Employer:
	/ /		

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone:
			- -

Insured's SSN:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize San Diego Orthodontic Specialists to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to San Diego Orthodontic Specialists. I permit a copy of this authorization to be used in place of the original. I give San Diego Orthodontic Specialists, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /

Dental History

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Previous Dentist

Dentist Name:	Dental Practice Name:	Phone:
		- -

Last Dental Visit

Last Dental Visit (m/y):
/

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:
Yes

What is the main reason for your visit today?
❑ Comments:

Dental Concerns

Check all that apply.

Teeth

❑ Broken or chipped	❑ Difficulty chewing	❑ Food trap areas	❑ Missing teeth
❑ Crooked	❑ Loose teeth	❑ Grinding or clenching	❑ Sensitive when biting

Facial/Jaw Pain

❑ Frequent headaches	❑ Popping/clicking	❑ Pain in jaw	❑ Head injury
❑ Avoid certain foods	❑ Jaw locks open/closed	❑ Jaw injury	❑ Neck injury

Other Concerns

❑ Biting cheeks or lip	❑ Sleep apnea	❑ Retainer
❑ TMJ	❑ Tooth replacement	
❑ Nail-biting	❑ Snoring	

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?
Yes

Have you ever had:

Check all that apply.

❑ Orthodontic treatment	❑ Periodontal treatment	❑ Your bite adjusted
❑ Oral surgery	❑ Your teeth ground	❑ A bite plate or mouth guard

❑ Any canker sores or cold sores on your lips, tongue, gums, or body
❑ A serious injury to the mouth or head? If yes, please describe including cause:

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Medical History

How is your general health? ❍Good ❍Fair ❍Poor

Are you currently under medical treatment? If yes, what for?

Yes

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Yes

Physician's Name:	Phone: - -	Last Visit: /

Do we have permission to contact your doctor regarding your care? ❍Yes ❍No

Have you ever had:

Check all that apply.

- ❑ Arthritis
- ❑ Cancer
- ❑ Emotional problems
- ❑ Heart murmur/trouble
- ❑ History of substance abuse/drug addiction
- ❑ Kidney problems
- ❑ Allergies
- ❑ Asthma
- ❑ Blood disease
- ❑ Diabetes
- ❑ Hepatitis A, B, or C
- ❑ Hypertension (high blood pressure)
- ❑ Liver problems
- ❑ Anemia
- ❑ Epilepsy
- ❑ Seizures
- ❑ Fainting
- ❑ Hearing disorders
- ❑ High or low blood sugar
- ❑ Hypotension (low blood pressure)
- ❑ Nervous disorder
- ❑ Rheumatic fever
- ❑ Heart attack/stroke
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Artificial valves
- ❑ Congenital heart defect
- ❑ Mitral valve prolapse
- ❑ Artificial bones/joints
- ❑ Shingles
- ❑ HIV/AIDS
- ❑ Blood transfusions
- ❑ Fever blisters
- ❑ Severe/frequent headaches
- ❑ Cancer/chemotherapy
- ❑ Radiation treatments
- ❑ Psychiatric problems
- ❑ Tuberculosis
- ❑ Venereal disease
- ❑ Hemophilia
- ❑ Abnormal bleeding
- ❑ Ulcers/colitis
- ❑ Difficulty breathing
- ❑ Hospitalized for any reason
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Artificial hip/joints
- ❑ Convulsions
- ❑ Herpes
- ❑ Heart disease
- ❑ Scarlet fever
- ❑ Sickle cell anemia
- ❑ Sinus trouble
- ❑ Cough-persistent or bloody
- ❑ Latex sensitivity

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- ❑ Acrylic
- ❑ Aspirin
- ❑ Codeine
- ❑ Dental anesthetics
- ❑ Erythromycin
- ❑ Latex rubber
- ❑ Metals
- ❑ Penicillin/antibiotics
- ❑ Tetracycline

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:
Yes

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ❍Yes ❍No

Do you smoke or chew tobacco? ❍Yes ❍No

Have you been treated in a hospital in the last five years? ❍Yes ❍No

If female, please mark if you are:
❏ Pregnant - If so, please enter your due date or week #:
❏ Trying to get pregnant ❏ Nursing ❏ On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use:
Reviewed by: Title: Date: / /