CULVER CITY Orthodontics
For Children & Adults

PATIENT INFORMATION

Patient's Name _____

Prefers to be called_____

Home Address_____

City _____Zip Code_____

Home# (_____) _____

Cell# (_____) _____

E-Mail _____

Birth Date_____ Age_____Sex ☐ Male ☐ Female

SS#/INS ID#_____

Employer_____

Work# (_____) _____

Occupation_____

Orthodontic Insurance_____

Patient's Dentist_____

Address_____

Phone# (_____) _____

Who referred you? _____

RESPONSIBLE PARTY

(FILL OUT INFORMATION IF DIFFERENT FROM ABOVE)

Name_____Marital Status_____

Address_____

City _____Zip Code_____

Home# (_____) _____

Cell# (_____) _____

E-Mail _____

SS#/INS ID#_____ Birth Date_____

Relationship to Patient _____

Employer_____

Occupation_____

Work# (_____) _____

Orthodontic Insurance_____

Spouse's Name_____ Marital Status_____

Address_____

City _____Zip Code_____

Home# (_____) _____

Cell# (_____) _____

E-Mail _____

SS#/INS ID#_____ Birth Date_____

Relationship to Patient _____

Employer_____

Occupation_____

Work# (_____) _____

Orthodontic Insurance_____

MEDICAL HISTORY

Has the patient been under the care of a physician within the past 2 years?

Explain the condition and duration:_____

_____

Does the patient have a history of any of the following?

Y	**N**	Mental Disorders	**Y**	**N**	Fainting or Dizziness
Y	**N**	Venereal Disease	**Y**	**N**	Arthritis
Y	**N**	Hepatitis	**Y**	**N**	Anemia
Y	**N**	AIDS or HIV Positive	**Y**	**N**	Have you ever taken "Phen-Phen" or "Redux"
Y	**N**	Epilepsy	**Y**	**N**	Heart Trouble
Y	**N**	Diabetes	**Y**	**N**	Prolonged Bleeding
Y	**N**	Rheumatic Fever	**Y**	**N**	High or Low Blood Pressure
Y	**N**	Asthma			

List any other serious illnesses or operations not mentioned above:

_____

List any drugs or medication presently being taken. Give reason:

_____

_____

List any allergies or drug sensitivities:_____

_____

FEMALE PATIENTS

Y **N** Are you pregnant

Y **N** Are you anticipating becoming pregnant

DENTAL HISTORY

Y **N** Is there any pain or clicking in the jaw joints?

Y **N** Does the jaw ever lock after opening?

Y **N** Do you clench or grind your teeth?

Y **N** Abnormal swallowing habits (tongue thrust)?

Y **N** Have there been any injuries to the mouth, teeth, or jaw?

Y **N** Has the patient ever seen an Orthodontist, had orthodontic treatment, worn a "retainer", or "bite plate"?
If so when?_____
By whom?_____

When were the last dental x-rays? _____

When was the last teeth cleaning? _____

What is your reason for seeking an orthodontic evaluation?

_____

_____

List anything else you think the doctor should know.

_____

I have truthfully answered all the above questions and agree to inform this office of any changes in medical or dental history on the above stated patient. In addition, I authorize the doctor to perform a complete orthodontic evaluation.

Signature: _____ Date_____

Relationship to patient_____

IF YOU HAVE DENTAL INSURANCE, PLEASE PRESENT YOUR CARD TOTHE FRONT OFFICE STAFF.