

Welcome



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you to help achieve your ideal smile.

1. Patient Information

DATE _____

Name _____
Last Name First Name Middle Initial

Preferred Name _____

D.O.B. ____/____/____ Sex Male Female

Home Phone (____) _____ Cell Phone (____) _____

Address _____ Ste./Apt.# _____

City _____ State _____ Zip _____

Email _____ Occupation _____

Patient Employer/School _____

Employer/School Address _____

In case of an emergency, who should we notify?

Relationship to patient _____ Phone No.(____) _____

How did you hear about our office/whom may we thank for referring you?

2. Person Responsible for Account

Name _____
Last Name First Name Middle Initial

Relationship to patient _____

Married Widowed Single

Separated Divorced Partnered for ____ yrs.

Address _____ Ste./Apt.# _____

City _____ State _____ ZIP _____

Home Phone (____) _____ Cell Phone (____) _____

Employer _____

Employer Address _____

DL # _____ SS# _____

Additional person authorized on account Yes No

Name _____
Last Name First Name Middle Initial

Relationship to patient _____

Authorized access to	Account info/billing	<input type="checkbox"/> yes <input type="checkbox"/> no
	Treatment updates	<input type="checkbox"/> yes <input type="checkbox"/> no
	Make appointments	<input type="checkbox"/> yes <input type="checkbox"/> no

3. Primary Dental Insurance

Orthodontic Coverage? YES NO

Insurance Co. Name _____

ID or Social Security# _____

Insurance Co. Phone # (____) _____

Group # (Plan, Local or Policy #) _____

Policy Holder Name _____

Relationship to Patient _____

Policy Holder Birthdate ____/____/____

4. Secondary Dental Insurance

Orthodontic Coverage? YES NO

Insurance Co. Name _____

ID or Social Security# _____

Insurance Co. Phone # (____) _____

Group # (Plan, Local or Policy #) _____

Policy Holder Name _____

Relationship to Patient _____

Policy Holder Birthdate ____/____/____

5. Tell us about yourself

Hobbies _____

Favorite Color _____

Nickname _____

Musical instruments played _____

Have we treated any other family member? Y N

If yes, names _____

Tushar Shah D.D.S.
Pranav Patel D.D.S.
Bruce Wardell D.M.D.
Chirag Parikh D.M.D.
www.pashaorthodontics.com

Please Complete Both Sides

6. Patient Dental History

Have you ever been evaluated or had orthodontic treatment before? YES NO

If yes, by whom? _____ When? _____

General Dentist _____

Dentist Phone (____) _____ Date of Last Visit ____/____/____

How often do you brush? _____ How often do you floss? _____

Your dental health is Good Fair Poor

Please check if you have or have had any of the following

Bleeding gums, bad taste or mouth odor

Clenching/Grinding Teeth

Frequent oral habits (lip/finger/thumb sucking, nail biting, etc.)

If yes, please explain _____

Food impaction between the teeth

History of speech problems or speech therapy

Informed of any missing or extra permanent teeth

Injuries to the face, mouth, teeth or chin

If yes, please explain _____

Mouth breathing habit

Pain/tenderness or clicking/locking of your jaw joints (TMJ/TMD)

Snoring

Teeth sensitivity

Tongue Thrust (abnormal swallowing)

Other dental related issues _____

8. Authorization

All remaining payments are due in full prior to debanding date unless prior arrangements have been approved.

If this office accepts insurance, 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 payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE

DATE

Policy Agreement

I understand that the information that I have given 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 my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

SIGNATURE

DATE

7. Patient Medical History

Are you currently under the care of a physician? Yes No

If yes, physicians name _____

Are you pregnant? Yes No

Please check if you have or have had any of the following

<input type="checkbox"/> ADD/ ADHD	<input type="checkbox"/> Seizures /Epilepsy
<input type="checkbox"/> Adenoids or tonsils removed	<input type="checkbox"/> Serious illness or operations
<input type="checkbox"/> Anemia/Abnormal bleeding	_____
<input type="checkbox"/> Artificial bones/joints /valves	<input type="checkbox"/> Sinus problems/ difficulty breathing through nose
_____	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Vision, hearing or speech problems
<input type="checkbox"/> Birth defects or hereditary problems	_____
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Any other medical concerns / conditions
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes or low blood sugar	
<input type="checkbox"/> Fainting	Please list any medications/ prescriptions that you are currently taking
<input type="checkbox"/> Frequent headaches or migraines	_____
<input type="checkbox"/> Frequent ear infections/ colds/throat infections	_____
<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> HIV+ / AIDS	
<input type="checkbox"/> Handicaps/Disabilities	ALLERGIES
<input type="checkbox"/> Heart murmur or heart problems	_____
<input type="checkbox"/> Kidney/ Liver problems	_____
<input type="checkbox"/> Mental health disturbance/ depression	_____

Medical History update or changes for returning patients.

Have there been any changes in your health status since your last visit?

YES NO

If Yes, Please explain _____

SIGNATURE

DATE

OFFICE USE ONLY

Medical/dental information above has been renewed and entered in system file.

Staff initials

Date