WELCOME TO

UNIVERSITY ORTHODONTICS

Please fill out this form completely; it is important to your orthodontic care. Our goal is to help you reach and maintain good oral health and a beautiful smile that lasts a lifetime.

Today's Date:_____

About You:

Name:_____
LAST FIRST MI

Nickname:_____ □M □F

Birthdate:___/____/___Age:_____SS #:_____

Home # (_____)_____ Cell #: (____)_____

Home Address:_____

_____
CITY STATE ZIP

□single□married□partnered□separated□divorced □widowed

E-mail Address:_____

Employer:_____

Work #: (_____)_____

How long at current job:___ Job Title:_____

Hobbies/Sports:_____

When are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

General Dentist:_____

Date of last visit:_____

Spouse Information:

His/Her Name:_____

Employer:_____

Wk #: (___)_____Cell # (___)_____

Birthdate:___/____/___Age:_____SS #:_____

In the event of an emergency, whom should we contact?
Relationship:_____
Wk #: (___)_____Cell # (___)_____

Person Responsible for Account:

Name:_____Relation:_____

Billing Address:_____

_____
CITY STATE ZIP

Wk #: (___)_____Hm # (___)_____

Employer:_____

How long at current job:___ Job Title:_____

SS #:_____Birthdate:___/___/____

Primary Orthodontic Insurance

Orthodontic Coverage? □yes □no
Insurance Co. Name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #: (____)_____
Group # (plan, local or policy #):_____
Policy Owner's Name:_____
Relationship to patient:_____
Policy Owner's Birthdate: ____/____/_____
Policy Owner's ID #:_____
Policy Owner's Employer:_____

Secondary Orthodontic Insurance

Orthodontic Coverage? □yes □no
Insurance Co. Name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #: (____)_____
Group # (plan, local or policy #):_____
Policy Owner's Name:_____
Relationship to patient:_____
Policy Owner's Birthdate: ____/____/_____
Policy Owner's ID #:_____
Policy Owner's Employer:_____

Records to be taken at the Initial Exam include photos, panoramic and cephalometric x-rays. These records are provided at no cost, for use in our office, to aid Dr. Ogata with his comprehensive evaluation.

_____ _____
SIGNATURE OF PATIENT DATE

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____ _____
SIGNATURE OF PATIENT DATE

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 directly to this office.

_____ _____
SIGNATURE OF PATIENT DATE

Medical/Dental History

Do you like your smile? □YES □ NO
If not, what would you change? _____

Have you ever experienced any of the following?

Y N Clenching/ Grinding Teeth
Y N Lip Sucking/ Biting
Y N Nail Biting
Y N Nursing/Bottle Habits/Pacifier (circle)
Y N Thumb/Finger Sucking (if yes, what age___)
Y N Tongue Thrust

Y N DK/U Are you in good health? Date of most recent physical exam?_____ Your current physical health is : □Good □ Fair □ Poor
Allergic to the following: Latex: □YES □ NO Metals/Nickel: □YES □ NO Plastics: □YES □ NO allergies to any meds:_____

For the following questions circle YES, NO, OR DON'T KNOW/UNDERSTAND (DK/U). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Y N DK/U Birth defects or hereditary problems?
Y N DK/U Bone fractures, any major accidents?
Y N DK/U Rheumatoid or arthritic conditions?
Y N DK/U Endocrine or thyroid problems?
Y N DK/U Kidney problems?
Y N DK/U Diabetes?
Y N DK/U Cancer or been treated for a tumor?
Y N DK/U Stomach ulcer or hyperacidity?
Y N DK/U Polio, mononucleosis, tuberculosis, pneumonia?
Y N DK/U Problems of the immune system?
Y N DK/U Hepatitis, jaundice or liver problems?
Y N DK/U AIDS or HIV Positive?
Y N DK/U Sexually transmitted disease?
Y N DK/U Fainting spells, seizures, epilepsy, or neurologic disease?
Y N DK/U Mental health or behavioral problems?
Y N DK/U Vision, hearing, tasting or speech difficulties?
Y N DK/U Loss of weight recently, poor appetite?
Y N DK/U Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
Y N DK/U High or low blood pressure?
Y N DK/U Easily tired?
Y N DK/U Chest pain, shortness of breath or swelling ankles?
Y N DK/U Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
Y N DK/U Skin disorder?
Y N DK/U Do you have a normal and good diet?
Y N DK/U Frequent headaches, colds or sore throats?
Y N DK/U Any history of speech problems?
Y N DK/U Eye, ear, nose, throat condition?
Y N DK/U Hayfever, asthma, sinus trouble, hives?
Y N DK/U Tonsil or adenoid conditions?
Y N DK/U Allergies or drug reactions?
Y N DK/U Other physical problems or symptoms?

Y N DK/U Are you taking medication, nutrient supplements or non prescription medicine? Please name them & explain:
_____

Y N DK/U Do you currently have or ever had a substance abuse problem?
Y N DK/U Operations? For_____
Y N DK/U Hospitalized? For_____
Y N DK/U Being treated by another health care professional? For_____

Please discuss any medical problems that you may have:_____

FEMALE PATIENT

Y N DK/U Are you pregnant?
Y N DK/U Are you taking birth control pills?
Y N DK/U Are you anticipating becoming pregnant?

DENTAL HISTORY

Y N DK/U Chipped or otherwise injured permanent teeth?
Y N DK/U Teeth sensitive to hot or cold; teeth throb or ache?
Y N DK/U Jaw fractures, cysts, mouth infections?
Y N DK/U "Dead Teeth", root canals treated?
Y N DK/U Bleeding gums, bad taste, mouth odor?
Y N DK/U Periodontal "Gum Problems"?
Y N DK/U Food impaction between teeth?
Y N DK/U "Gum Boils", frequent canker sores, cold sores?
Y N DK/U Mouth breathing habit, snoring, difficulty in breathing?
Y N DK/U Tooth grinding, jaw clenching, clicking, locking?
Y N DK/U Do you experience any pain or soreness in the muscles of your face, or around the ears?
Y N DK/U Any pain in jaw or ringing in the ears? (RT, LT, Both)
Y N DK/U Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)
Y N DK/U Difficulty encountered in chewing or jaw opening?
Y N DK/U History of supernumerary (extra) or congenitally missing teeth?
Y N DK/U Have any permanent teeth been removed?
Y N DK/U Aware of loose, broken or missing restoration (fillings)?
Y N DK/U Any teeth irritating cheek, lip, tongue, palate?
Y N DK/U Have you ever had Orthodontic treatment?
Y N DK/U Have you recently been under another dentist's care? Specialist_____
Y N DK/U Have you ever had Periodontal (gum) treatment?
Y N DK/U Concerned about spaced, crooked, protruding teeth?
Y N DK/U Aware or concerned about under or over developed jaw?
Y N DK/U Any relative with similar tooth or jaw relationships?
Y N DK/U Any wisdom tooth problems?
Y N DK/U Have you had any serious trouble associated with any previous dental treatment?

What is your primary concern- Why are you here?_____
Date of most recent dental examination_____ How often do you brush_____ floss_____
Would you like to discuss anything with the Doctor in private? □ YES □ NO

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?
_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.
If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____ _____
SIGNATURE OF PATIENT DATE

OFFICE USE ONLY

Doctor's Comments:_____
_____
_____
_____