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WELCOME TO OUR OFFICE!

PATIENT INFORMATION

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____ School _____

Patient: _____ (Email Address) Responsible Party: _____ (Email Address)

RESPONSIBLE PARTY INFORMATION

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes __ No __ If Yes, please continue: _____

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

Medical History

Physician's Name _____ Last Visit _____ Phone Number _____

Current physical condition ☐Good ☐Fair ☐Poor Are you currently under the care of a physician? ☐Yes ☐No

Have you ever been under the care of a physician for a major illness? ☐Yes ☐No _____

Please answer all questions by checking 'Yes' or 'No".

Good Health	☐Yes	☐No	Bleeding disorder	☐Yes	☐No
Recent illness	☐Yes	☐No	Prolonged bleeding	☐Yes	☐No
Recent cold, cough	☐Yes	☐No	Leukemia	☐Yes	☐No
Heart or chest pain	☐Yes	☐No	Sickle cell anemia	☐Yes	☐No
Heart murmur	☐Yes	☐No	Anemia	☐Yes	☐No
High blood pressure	☐Yes	☐No	Joint replacement	☐Yes	☐No
Rheumatic fever	☐Yes	☐No	Arthritis	☐Yes	☐No
Kidney disease	☐Yes	☐No	Asthma	☐Yes	☐No
Lung disease	☐Yes	☐No	Sinus problems	☐Yes	☐No
Diabetes	☐Yes	☐No	Hay fever, seasonal allergies	☐Yes	☐No
Hepatitis	☐Yes	☐No	Nasal obstruction	☐Yes	☐No
Herpes (cold sores)	☐Yes	☐No	Severe headaches	☐Yes	☐No
AIDS or HIV positive	☐Yes	☐No	Bone disorder	☐Yes	☐No
Endocrine disorder	☐Yes	☐No	Epilepsy	☐Yes	☐No
Growth disorder	☐Yes	☐No	Canker Sores	☐Yes	☐No
Tonsils/Adenoids removed	☐Yes	☐No	Antibiotics required for Dental appointments	☐Yes	☐No

List any drugs (prescription and over the counter) _____
that you are currently taking and please give reason _____

List any allergies or sensitivities _____
Including drug, latex metal or other _____
_____

Are you taking any medication for osteoporosis? If so, what and for how long? _____

Are you now, or could you be pregnant? ☐Yes ☐No If yes, how many weeks? _____

Dental History

What are the main concerns you would like orthodontics to accomplish? _____
_____

Current Dental Health ☐Good ☐Fair ☐Poor Do you like your smile? ☐Yes ☐No

Have you ever been treated with orthodontics before? ☐Yes ☐No If yes, please explain: _____

_____

Do you have any history of gum or periodontal disease? ☐Yes ☐No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ☐Yes ☐No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐Yes ☐No

Have you ever had injuries to your face, mouth, teeth or chin? ☐Yes ☐No

Do you generally breathe through your mouth? Awake: ☐Yes ☐No Asleep ☐Yes ☐No

Do you have any missing or extra permanent teeth? ☐Yes ☐No If yes, please explain: _____

_____

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

Signature _____ **Date** _____