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**Welcome to Dr. Aaron Rondons Office!**

**ADULT PATIENT INFORMATION**

DATE: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name/Initial: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female I prefer to be called: \_\_\_\_\_

SSN: \_\_\_\_\_ Driver's License: \_\_\_\_\_ Home Phone No.: \_\_\_\_\_ Cell # \_\_\_\_\_

Email address: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Single Married Widowed Separated Divorced

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Years with employer: \_\_\_\_\_

Name of your Dentist: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Reason: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Who is financially responsible for this account? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SS #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

SS #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Occupation: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Policy Holder's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employed by: \_\_\_\_\_ Dental Insurance Company: \_\_\_\_\_

Secondary Policy Holder's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employed by: \_\_\_\_\_ Dental Insurance Company: \_\_\_\_\_

**MEDICAL HISTORY**

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

**Now or in the past, have you had:**

yes no Bone fractures, any major accidents?

yes no Rheumatoid or arthritic conditions?

yes no Endocrine or thyroid problems?

yes no Kidney problems?

yes no Stomach ulcer or hyperacidity?

yes no Diabetes? Cancer, tumor, radiation treatment or Chemotherapy?

yes no Polio, mononucleosis, tuberculosis, pneumonia?

yes no AIDS or HIV positive?

yes no Hepatitis, jaundice or liver problem?

yes no Fainting spells, seizures, epilepsy problem?

yes no Mental health disturbance or depression?

yes no Vision, hearing, tasting or speech difficulties?

yes no History of eating disorder (anorexia, bulimia)

yes no Excessive bleeding or bruising tendency, anemia or bleeding disorder?

yes no High or low blood pressure?

yes no Chest pain, shortness of breath or swelling ankles?

yes no Cardiovascular problem (heart trouble, heart attack, angina, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

yes no Do you have a well-balanced diet?

yes no Frequent headaches, colds, or sore throats?

- yes no Hay fever, asthma, sinus trouble or hives?
- yes no Tonsil or adenoid conditions?
- yes no Osteoporosis?

**WOMEN ONLY**

- yes no Are you pregnant?

**DENTAL HISTORY**

**Now or in the past have you ever had:**

- yes no Supernumerary (extra) or congenitally missing teeth?
- yes no Chipped or injured primary (baby) or permanent teeth?
- yes no Teeth sensitive to hot or cold: teeth throb or ache?
- yes no Jaw fractures, cysts or mouth infections?
- yes no Bleeding gums, bad taste or mouth odor?
- yes no Periodontal "gum problems"?
- yes no "Gum boils" frequent canker sores or cold sores?
- yes no Thumb, finger or sucking habit?  
Until what age? \_\_\_\_\_
- yes no Abnormal swallowing habit (tongue thrusting)?
- yes no Mouth breathing habit, snoring or difficulty in breathing?
- yes no Tooth grinding or jaw clenching?
- yes no Any pain, clicking or locking in jaw or ringing in the ears?
- yes no Any pain or soreness in the muscles of the face or around the ears?
- yes no Difficulty in chewing or jaw opening?

**Allergies or reactions to any of the following:**

- yes no Local anesthetics (Novocain or Lidocaine)
- yes no Aspirin or Ibuprofen (Motrin, Advil)
- yes no Penicillin or other antibiotics
- yes no Sulfa drugs
- yes no Codeine or other narcotics
- yes no Metals (jewelry, clothing snaps)
- yes no Latex (gloves, balloons) Acrylic
- yes no Other substances (specify) \_\_\_\_\_
- yes no Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them:  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_
- yes no Do you currently have or ever had a substance abuse problem?
- yes no Do you chew or smoke tobacco?
- yes no Other physical problems or symptoms? Describe: \_\_\_\_\_  
\_\_\_\_\_
- yes no Being treated by another health care professional?  
For: \_\_\_\_\_
- Date of most recent physical exam? \_\_\_\_\_
- Do you have any other medical conditions that we should know about?  
\_\_\_\_\_
- Jaw size imbalance \_\_\_\_\_
- yes no Concerned about spaced, crooked or protruding teeth?
- yes no Aware or concerned about under or over developed jaw?
- yes no Had periodontal (gum) treatment?
- yes no Had any serious trouble associated with any previous dental treatment?
- yes no Ever had a prior orthodontic examination or treatment?
- How often do you brush: \_\_\_\_\_ Floss: \_\_\_\_\_
- What is your primary concern? Why are you here? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Complete Address \_\_\_\_\_  
Street
City
State
Zip

**SIGNATURES & INITIALS**

1. \_\_\_\_\_ 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.
2. \_\_\_\_\_ I authorize release of any information leading to insurance claims for this patient and authorize payment directly to Dr. Aaron Rondon, of the group insurance benefits.
3. \_\_\_\_\_ I realize that a credit report may be necessary in determining a payment plan for the Orthodontic treatment.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Staff Member Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_