Welcome to Dr. Aaron Rondon's 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: ______________

Years at above address: _________If less than 5 years at current address, previous address: __________________________________

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation: ___________________________ Employer: _________________________________ Years with employer: __________

Name of your Dentist: ____ Phone number:______________________________

Dentist's Address: ____

Date Last Seen: _____________________________ Reason: ____

Physician's name: ____ Phone number:______________________________

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:__________________________ Middle Name/Initial:_________

Spouse's Employer: ___________________________ Occupation: __________________________ No. Years Employed: _________

SS #: ______________________________________ Birth Date: ___________________________

INSURANCE INFORMATION

Insurance coverage for dental treatment? ☐Yes ☐No Insurance coverage for orthodontic treatment? ☐Yes ☐No

Primary Policy Holder's Name: ________________________________SSN:_________________________Birth Date: ___________

Employed by: ____Dental Insurance Company: ___________________________

Group #: ______________Local #:________Do you have dual coverage? ☐Yes ☐No If Yes, please continue.

Secondary Policy Holder's Name: _______________________ SSN:_________________________Birth Date:____________________

Employed by: ____Dental Insurance Company: ___________________________________

Medical Insurance Company: ____Group #: __________________________

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: ______________