DOCTOR SMILES
orthodontics

Dr. Marisela Bedoya, DMD, DHSc

ADULT PATIENT INFORMATION

Date:

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home phone _____ Cell phone _____ Email _____

Male ☐ Female ☐ Date of Birth _____ Age _____ SSN _____ Work phone _____

Employer _____ Employer's Address _____ Occupation _____

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Who will be responsible for the account? Self ☐ Spouse ☐ Other ☐

If other, who will be responsible? _____

Whom may we thank for referring you to our office? _____

List any family members or friends that have been treated in this office _____

ORTHODONTIC INSURANCE INFORMATION

PRIMARY

Insured's Name _____ Insured's SSN _____

Insurance Company _____ Insurance Company Address _____

Policy/Group # _____ Insurance Company Phone _____ Insured's Date of Birth _____

SECONDARY

Insured's Name _____ Insured's SSN _____

Insurance Company _____ Insurance Company Address _____

Policy/Group # _____ Insurance Company Phone _____ Insured's Date of Birth _____

I hereby authorize the release of any information relating to this claim and authorize payment of insurance benefits directly to Doctor Smiles Orthodontics.

_____ _____
Signature Date

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Are you taking any medications? Yes ☐ No ☐ If yes, please list _____

Are you in good health? Yes ☐ No ☐

Do you have a history of any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Abnormal bleeding	☐	☐	Cancer	☐	☐	Kidney disorders	☐	☐	Seasonal allergies	☐	☐
AIDS/HIV	☐	☐	Craniofacial syndromes	☐	☐	Lung disorders	☐	☐	Sinus problems	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Migraines	☐	☐	STDs	☐	☐
Arthritis	☐	☐	Difficulty breathing	☐	☐	Mitral valve problems	☐	☐	Surgery	☐	☐
Artificial joints/valves	☐	☐	Drug/alcohol abuse	☐	☐	Orofacial clefts	☐	☐	Thyroid problems	☐	☐
Asthma	☐	☐	Epilepsy/seizures	☐	☐	Psychiatric problems	☐	☐	Tuberculosis	☐	☐
Blood disorders	☐	☐	Heart disorders	☐	☐	Radiation treatment	☐	☐	Ulcers/colitis	☐	☐
Blood transfusions	☐	☐	Hepatitis	☐	☐	Rheumatic fever	☐	☐	Vision/hearing	☐	☐
Bone disorders	☐	☐	Hospitalization	☐	☐	Scarlet fever	☐	☐	Other	☐	☐

Please explain any "yes" responses _____

Please list any other medical alerts _____

Have adenoids and/or tonsils been removed? Yes ☐ No ☐ If yes, when? _____

Women Only:	Yes	No
Are you pregnant?	☐	☐
If yes, how far along _____		
Are you nursing?	☐	☐

Are you taking, or have you ever taken Bisphosphonate drugs? Yes ☐ No ☐

If yes, please list _____ Dose/Length of time _____

Are you allergic to any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Anesthetics	☐	☐	Cyclosporins	☐	☐	Latex	☐	☐	Sulfa drugs	☐	☐
Amoxicillin	☐	☐	Codeine	☐	☐	Metal	☐	☐	Tetracycline	☐	☐
Aspirin	☐	☐	Erythromycin	☐	☐	Penicillin	☐	☐	Other	☐	☐

Please list any other drugs or material you may be allergic to _____

DENTAL HISTORY

Dentist's Name _____ Date of last visit _____

What concerns you most about your teeth? _____

Do you have a history of any of the following?

	Yes	No		Yes	No		Yes	No
Complication following dental treatment	☐	☐	Injury to teeth	☐	☐	Use of fluoride products	☐	☐
Dental problems	☐	☐	Jaw clicking/popping	☐	☐	Other	☐	☐
Grind/clench teeth	☐	☐	Jaw pain	☐	☐			
Injury to face or jaw	☐	☐	Toothaches or cavities	☐	☐			

Please explain any "yes" responses _____

Please list any other dental alerts _____

Do you need pre-medication before dental treatment? Yes ☐ No ☐

I certify that the information in this form is true and correct to the best of my knowledge. I will notify this practice should there be any future changes in my medical or dental status.

_____ _____

Signature Date