WELCOME

Ashraf Orthodontics
children & adults

ABOUT YOU

Name: _____
First Middle Last

I prefer to be called:_____ Gender: □ Male □ Female Birthdate: _____/_____/_____

What is your primary concern?_____

_____

_____

Home Address: _____
Street City Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____

Occupation:_____ Employer: _____ Years Employed: _____

Marital Status: □ Single □ Married □ Divorced □ Separated

Spouse/Partner's Name: _____
First Middle Last

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation:_____ Employer: _____ Years Employed: _____

In the event of emergency, is there someone local that we may contact? Name: _____

Relationship: _____ Home: _____Cell: _____

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

MEDICAL HISTORY

Physician: _____ Date of Last Visit: _____/_____/_____

Please check Yes or No (If yes, please fill in details)

Are you taking any medication? _____ Yes □ No □

Has your physician advised prophylactic antibiotics for dental procedures? _____ Yes □ No □

Are you allergic to any medication? _____Yes □ No □

Are you allergic to latex or nickel? Any other allergies?_____ Yes □ No □

Have you had any major operations? _____ Yes □ No □

Have you ever been involved in a serious accident? _____ Yes □ No □

Are there any medical conditions we have not discussed that you feel we should be aware of? _____Yes □ No □

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MEDICAL HISTORY CONT.

Check any of the medical conditions below that you have had or currently have:

- □ Abnormal bleeding/ Hemophilia
- □ Anemia
- □ Arthritis
- □ Asthma or Hayfever
- □ Bone Disorder
- □ Congenital Heart Defect
- □ ADD/ ADHD
- □ Diabetes
- □ Dizziness
- □ Radiation/ Chemotherapy
- □ Gastrointestinal Disorders
- □ Heart Problems
- □ Heart Murmur
- □ Tumor or Cancer
- □ Hepatitis/ Liver Problems
- □ Herpes
- □ High Blood Pressure
- □ HIV/AIDS
- □ Kidney Problems
- □ Nervous Disorders
- □ Osteoporosis
- □ Pneumonia
- □ Prolonged Bleeding
- □ Epilepsy
- □ Rheumatic Fever
- □ Tuberculosis

FAMILY INFORMATION

Is there a family history of:

□ Arthritis □ Diabetes □ Severe Allergies □ Unusual Dental Problems □ Jaw Size Imbalance

Any other family medical conditions that we should be aware of?: _____

_____

DENTAL HISTORY

Current Dentist: _____ Date of Last Visit: _____/_____/_____

Please check Yes or No (If yes, please fill in details)

Are you presently in any dental pain? _____ Yes □ No □

Are you currently seeing any dental specialists? (Periodontist, Prosthodontist, Oral Surgeon)_____ Yes □ No □

Have you ever experienced any unfavorable reaction to dentistry? _____ Yes □ No □

Have you ever broken or chipped any teeth? _____ Yes □ No □

Has there been any injuries to your face, mouth, or teeth? _____ Yes □ No □

Is there any part of the your mouth sensitive to temperature or pressure? _____ Yes □ No □

Do your gums bleed when you brush? _____ Yes □ No □

Do you have periodontal (gum) problems? _____ Yes □ No □

Do you have any type of thumb or tongue habit? _____ Yes □ No □

Do you have a history of speech problem or therapy? _____ Yes □ No □

Do you have a history of mouth breathing, snoring, or sleep apnea? _____ Yes □ No □

Have you ever seen an orthodontist? If yes, who and when? _____ Yes □ No □

Do your teeth or jaw ever feel uncomfortable when they awake in the morning?_____ Yes □ No □

Are you aware of any jaw clicking or popping? _____ Yes □ No □

Are you aware of clenching or grinding his/her teeth during the day? _____ Yes □ No □

Do you have frequent headaches? _____ Yes □ No □

FINANCIAL INFORMATION

Person responsible for account:_____ Relationship to patient:_____

Billing Address: _____
Street City Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation:_____ Employer: _____ Years Employed: _____

Do you currently have dental insurance? Yes □ No □ Not Sure □

Does your dental insurance plan include orthodontic coverage? Yes □ No □ Not Sure □

Insured's Name:_____ Date of Birth:_____/_____/_____

Insured's Employer: _____

Insurance Company: _____

Group #: _____ Insured's ID#/SSN_____

Insurance Co. Claim's Address:_____
Street City Zip

Insurance Co. Phone Number: _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her team 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 promptly inform Ashraf Orthodontics.

Signed: _____ Date: _____/_____/_____

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