



PATIENT INFORMATION

Patient Name _____
(First) (Middle) (Last)
 Preferred Name (Nickname) _____ Gender _____ Birthdate _____
 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)

- Is the patient taking any medication? _____ Yes No
- Has the patient's physician advised prophylactic antibiotics for dental procedures? _____ Yes No
- Is the patient allergic to any medication? _____ Yes No
- Does the patient have a history of major illness? _____ Yes No
- Has the patient had any major operations? _____ Yes No
- Has the patient 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

Check any of the medical conditions below that the patient has had or currently has:

Abnormal Bleeding	Diabetes	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Radiation/Chemotherapy	High Blood Pressure	Epilepsy
Asthma or Hayfever	Gastrointestinal (GI) Disorders	HIV/AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous System Disorders	Tumor or Cancer

DENTAL HISTORY

Current Dentist _____ Date of Last Visit _____

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

- Is the patient presently in any dental pain? _____ Yes No
- Is the patient currently seeing any dental specialists (Periodontics, Oral Surgeon, Endodontist) _____ Yes No
- Has the patient experienced any unfavorable reaction to dentistry? _____ Yes No
- Has the patient broken or chipped any teeth? _____ Yes No
- Have there been injuries to face, mouth, or teeth? _____ Yes No
- Is any part of the patient's mouth sensitive to temperature or pressure? _____ Yes No
- Do the patient's gums bleed when they brush or floss? _____ Yes No
- Does the patient have any type of thumb or tongue habit? _____ Yes No
- Has the patient ever seen an orthodontist? If yes, please provide name and date. _____ Yes No
- Do the patient's teeth or jaws ever feel uncomfortable in the morning? _____ Yes No
- Is the patient aware of any clicking/popping with the jaw joints? _____ Yes No
- Have you heard the patient grind at night? _____ Yes No
- Does the patient have a history of frequent headaches? _____ Yes No

PATIENT INFORMATION

Home Address _____

Occupation _____ Employer _____ Years Employed _____

Cell Phone: _____ Alt. Phone _____

E-mail Address: _____

Preferred Contact Method for Appointment Reminders: Phone Call Text Email

FINANCIAL INFORMATION

Responsible Billing Party Self Other _____
(First Name) (Last Name)

Do you currently have dental insurance? Yes No

Insured's Name _____ DOB _____ Social Sec No _____

Insured's Employer _____ Insurance Company _____

Insurance Company Address _____

Group Number _____ Insurance ID _____

BENEFITS

Benefits of orthodontics include an improvement in the appearance of the teeth, improvement in the general function of the teeth, and improvement in general dental health. Teeth, gums, and jaws are intricate parts of the craniofacial complex and can sometimes fail to respond to treatment ideally. I have truthfully answered all the above questions and agree to inform the office of any changes in medical or dental history. In addition, I authorize Dr. Sachee Parikh to perform a complete orthodontic evaluation.

Patient Signature _____

Date _____

Parikh Orthodontics
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