PATIENT INFORMATION

Patient Name ____
(First) (Middle) (Last)

Preferred Name (Nickname) ____________ Gender ____________ Birthdate ____________

Please list any hobbies/interests ____

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 ☐

FAMILY INFORMATION

☐ Same as previously examined sibling: ______________________________

Mother's Name ______________________________

Occupation ______________ Employer ______________ Years Employed ________

Home Address ______________________________

Cell Phone: ______________ Alt. Phone ______________

E-mail Address: ______________________________

Preferred Contact Method for Appointment Reminders: ☐ Phone Call ☐ Text ☐ Email

Father's Name ______________________________

Occupation ______________ Employer ______________ Years Employed ________

Home Address ______________________________

Cell Phone: ______________ Alt. Phone ______________

E-mail Address: ______________________________

Preferred Contact Method for Appointment Reminders: ☐ Phone Call ☐ Text ☐ Email

Parent Status ☐ Married ☐ Divorced // Step-Parent(s) Name (if applicable)______________

Sibling Name ______________ Age ________
(First) (Last)

Sibling Name ______________ Age ________
(First) (Last)

FINANCIAL INFORMATION

Responsible Billing Party ☐ Father ☐ Mother ☐ 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 (Parent if under 18) Signature ______________________________ Date ______________

Parikh Orthodontics
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