Dr. Steve Scott
Orthodontic Specialist
www.drstevescott.com

9098 Laguna Main St., Suite 4-B, Elk Grove, CA 95758 (916) 691-2912

Pt. # __________

WELCOME TO OUR PRACTICE

ADULT

ABOUT YOU

Please take this time to tell us about yourself.

Today's Date: ________________________________

Name: ________________________________
LAST FIRST MI MR MRS MS DR

Nickname: ______________________ ❑ Male ❑ Female

Birthdate: ______/______/______ Age: _______

SS #: ________________________________

Home Address: ________________________________
APT #

____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: ______________ Pager/Other #: ______________

Wk #: ______________ Ext: _____ DL # ______________

Employer: ________________________________

Employer's Address: ________________________________

How long there? __________ Occupation: ______________

When and where are the best times to reach you? ______________

____

General Dentist: ________________________________

Last Visit Date: ________________________________

Last Cleaning Date: ________________________________

SPOUSE INFORMATION

His/Her Name: ________________________________

Employer: ________________________________

Wk #: ______________ Ext: _____ SS #: ______________

Birthdate: _____/_____/_____

Person Responsible For Account

Name: ________________________________

Wk: ______________ Ext. ______ Hm #: ______________

Billing Address: ________________________________

____
City State Zip

Employer: ______________________ DL #:______________________

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ________________________________

Insurance Co. Address: ________________________________

Insurance Co. Phone #: ________________________________

Group # (Plan, Local or Policy #): ______________________

Insured Name: ______________________ Relation: ______________

Insured's Birthdate: ____/____/____ SS # ______________________

Insured's Employer: ________________________________

Secondary Orthodontist Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ________________________________

Insurance Co. Address: ________________________________

Insurance Co. Phone #: ________________________________

Group # (Plan, Local or Policy #): ______________________

Insured Name: ______________________ Relation: ______________

Insured's Birthdate: ____/____/____ SS # ______________________

Insured's Employer: ________________________________

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: ______________________

Relationship:______________

Wk #: ______________________ Hm #: ______________________

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MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:________________________________

Phone #:______________________ Date of last visit:__________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Are you taking any prescription / over-the-counter drugs? ❑ Yes ❑ No

Please list each one:________________________________

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # __________

Are you nursing? ❑ Yes ❑ No

Have you ever ad any of the following diseases or medical problems?

Y N Anemia/ Radiation Treatment
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Diabetes/Tuberculosis (TB)
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abn. Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Any Reason Hospitalized
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe Headaches
Y N Shingles
Y N Sinus Problems
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

____

Are you allergic to any of the following?

Y N Aspirin
Y N Metal/Plastic
Y N Codeine
Y N Dental Anesthesia
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs to which you are allergic:______________

____

This office reserves the right to verify the credit status of potential and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services o one or more credit reporting services.

____
Signature of parent or guardian Date

What are the main concerns that you would like orthodontics to accomplish?

____
____
____

Have you ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever had any pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Do you brush your teeth daily? ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

Have you ever had an injury to your: **Mouth Teeth Chin**

Do you have any speech problems? ______________________

____

Do you generally breathe through your mouth?
Y N Awake Y N Asleep?

Do you have any extra or missing teeth? ❑ Yes ❑ No

I understand that the information that I have given today is current to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in medical status. **I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment with my informed consent.**

____
Signature of parent or guardian Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctor's Comments: ______________________________
____
____

Initials: ____________ Date: ____________