Radiant Orthodontics

Let us create a Radiant Smile that lasts you a lifetime!

Patient Information

Date:

Patient Name………

Address…………………………………………………………… City……………………State………Zip…………………………

Phone……………………………………………………Birth Date........./………/………Social Security #...

Email Address………

If patient is a minor, give parent/guardian name……………………………………………………………………………

Family Dentist…………………………………………………………………………………When last seen………/………/………

Is any dental work pending?.....................Please describe………………………………………………………………………

Whom may we thank for referring you to this office?...

School……

Sibling/Children information:

Name………………………………………………………………………………Sex…………..DOB………/………/………

Name………………………………………………………………………………Sex…………..DOB………/………/………

Patient's Hobbies/Interest...

………

Responsible Party

Name………………………………………………………………………………..Marital Status………………………………………

Address……………………………………………………………………City…………………..State……………Zip…………………

Home Phone…………………………………Work Phone…………………………………Cell……………………………………………

Relationship to Patient……………………………………DOB………/………/………Social Security #..

Employer………………………………………………Occupation…………………………………Years Employed…………………...

Spouse's Name……………………………………………………………………Relationship to Patient……………………………..

Phone………………………………………………………………………Cell……………………………………………………

Dental Insurance

Policy Holder's Name……………………………………………Insurance Member ID #...

Insurance Company……………………………………Group #..Phone…………………………………..

Policy Holder's Employer…..………………………………………………………………………………………………

Do you have dual coverage? Yes……No…… If yes, please complete the following:

Policy Holders Name……………………………………………..Insurance Member ID #...

Insurance Company……………………………………Group #..Phone…………………………………..

Insured's Employer……….

As a courtesy to our patients we file your insurance claim forms. We will attempt to obtain as much insurance coverage for you as possible. However, please understand that you are responsible, in full, for all charges rendered. Any insurance estimates provided by this office should be considered a guideline only. When final insurance payment is received, your account will be reconciled.
I authorize the release of any information necessary to process my insurance claim and also, hereby authorize payment of insurance benefits to Radiant Orthodontics, Elaheh Moheb D.D.S

Initials………………………….

Emergency Contact Information

Emergency Contact…………………………………………………………Phone……………………………………………………...

Relationship to Patient………

Complete Address………...

We make every attempt to schedule appointments for convenience, but orthodontic appointments may infringe on your work/school schedule. Please initial that you understand about appointment scheduling

Initials…………………………….

I understand that records are stored electronically and that an electronic copy shall be considered an original for all purposes.

Initials…………………………..

Patient Signature…………………………………………………………………………………..Date……../………/……….

Parent Signature if minor…………………………………………………………………………Date………/………/………

Please complete the following health questionnaire as **fully and completely as possible.**
Also, write in any other information that you feel might be helpful.

What are the patient's or parent's main concerns regarding the jaws and teeth?

- ☐ Misalignment
- ☐ Crowding
- ☐ Overbite
- ☐ Crossbite
- ☐ Underbite
- ☐ Openbite
- ☐ Buck Teeth
- ☐ Protrusion of teeth
- ☐ Irregularly Shaped Teeth
- ☐ Gummy Smile
- ☐ Spacing
- ☐ Receded Jaw
- ☐ Prominent Jaw
- ☐ Irregular Facial Proportions
- ☐ Gum Disease
- ☐ Missing Teeth
- ☐ Jaw Dysfunction
- ☐ Mouth Too Small
- ☐ Clicking Jaw Joint
- ☐ Ringing in ears
- ☐ Headaches/Facial Pain
- ☐ Neck Pain
- ☐ Jaw Pain
- ☐ Second Opinion
- ☐ Dentist Recommended
- ☐ Other……………………………
  …………………………………

Patient's current physical health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Patient's current mental health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

List all current medications taken by patient:

- ☐ None
- ☐ Heart Pills
- ☐ Antibiotics
- ☐ Pain Pills
- ☐ Birth Control Pills
- ☐ Muscle Relaxants
- ☐ Anti-Anxiety/Anti Depressants
- ☐ Bisphosphonates
- ☐ Other……………………………
- ☐ Name……………………………
  …………………………………..

How often does the patient have dental checkups?

- ☐ Once per year
- ☐ Twice per year
- ☐ More than twice
- ☐ Only in case of emergency
- ☐ Never

Has the patient ever had, or now have any of these following conditions? Check all that apply.

- ☐ Allergy: Seasonal
- ☐ Allergy: Penicillin
- ☐ Allergy: Latex
- ☐ Allergy: Nickel
- ☐ Antibiotic Premedication
- ☐ Finger/Thumbsucking Habit
  Current……...Previous……..
- ☐ Bite Nails
- ☐ Plays Musical Wind Instrument
- ☐ Severe Head or Facial Injury
- ☐ Previous TMJ Treatment
- ☐ History of Orthognathic Surgery
- ☐ Repaired Cleft Lip/Palate
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease or Murmur
- ☐ Tuberculosis
- ☐ AIDS or HIV Positive
- ☐ Hepatitis
- ☐ Prolonged Bleeding
- ☐ Anemia
- ☐ Blood Disease
- ☐ Rheumatic Fever
- ☐ Tumors or Cancer
- ☐ Osteoporosis
- ☐ Bone Disorders
- ☐ Autoimmune
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Sleep Disturbance
- ☐ Loud Snoring
- ☐ Mouthbreathing
- ☐ Tonsilitis
- ☐ Tonsils Removed
- ☐ Adenoids Removed
- ☐ Mononucleosis
- ☐ Eating Disorder
- ☐ Emotional Stress
- ☐ Smoking/tobacco/alcohol/drug use
- ☐ None of the Above

Does this patient have difficulty chewing?

- ☐ Yes
  ....Teeth don't meet well
  ……..Pain when chewing
- ☐ No

Does the patient have pain/clicking in the jaw joint?

- ☐ Yes
- ☐ No

Does the patient grind/clench the teeth?

- ☐ Yes
- ☐ No

Has the patient ever been told they have a tongue thrust swallowing pattern?

- ☐ Yes
- ☐ No

Has the patient had a previous orthodontic examination/consult?

- ☐ Yes (When……………….)
- ☐ No

What is the patient's interest in orthodontic treatment?

- ☐ Eager to start treatment
- ☐ Wants treatment
- ☐ Treatment only if necessary
- ☐ Unwilling, but will cooperate if treatment is needed
- ☐ Uncooperative

Has child reached puberty?

- ☐ Yes (approx. date…………)
- ☐ No

Are you pregnant?

- ☐ Yes
- ☐ No

Are there any medical, dental, or surgical problems which have not been covered on this form?

- ☐ Yes
  ………………………………
  ………………………………
- ☐ No

……………………………………......
Signature of person filling out form

……………………………………..
Printed Name

……………………………………..
Date