PHELPS & COHEN ORTHODONTICS
Eric Phelps • DDS, MS
Jason Cohen • DDS, MS

NEW PATIENT INFORMATION

www.PCOrtho.com
T (408) 298-3433 | F (408) 298-6304

PATIENT INFORMATION

Patient Name: _____

Nick Name: _____

DOB: _____ Age: _____ ☐ Male ☐ Female

Address: _____

City, State Zip: _____

Home phone: _____

Cell phone: _____

Email: _____

Confirmation preference: ☐ Text ☐ Email

Employment status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired

Employer/School: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's name: _____

Who should we thank for referring you to our office?

_____

Has anyone else in your family been treated by our office?

_____

RESPONSIBLE PARTY INFORMATION

(If different from patient, complete below) ☐ Same as patient

Relationship: ☐ Parent ☐ Grandparent ☐ Guardian ☐ Spouse

☐ Other: _____

Name: _____

DOB: _____ ☐ Male ☐ Female

Address: _____

City, State Zip: _____

Home phone: _____

Cell phone: _____

Email: _____

SSN: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired

Employer/School: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's name: _____

FAMILY INFORMATION (if patient is a child)

The following information is requested so that we can communicate properly with the people involved in your child's treatment.

With whom does the patient live (custodial parent)? _____

Who should receive routine information about treatment progress? _____

Who should receive financial information? _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Policy holder: _____

Employer: _____

Insured's SSN: _____

Insured's DOB: _____

Insured's Address (if different from patient's):

_____

_____

Insurance Company: _____

Insured's Member ID: _____

Insured's Group #: _____

SECONDARY DENTAL INSURANCE

Policy holder: _____

Employer: _____

Insured's SSN: _____

Insured's DOB: _____

Insured's Address (if different from patient's):

_____

_____

Insurance Company: _____

Insured's Member ID: _____

Insured's Group #: _____

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HEALTH HISTORY

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Patient Name:_____ DOB:_____ Age:_____

MEDICAL HISTORY

Are you currently being treated or have you been treated within the last year by a physician? ☐ Yes ☐ No
For what condition?_____

Are you taking or have you been taking any drugs or medications within the last year? ☐ Yes ☐ No
Please list:_____

Have you had a major illness or been hospitalized within the last 5 years? ☐ Yes ☐ No
Describe:_____

Are you allergic or sensitive to any of the following?
☐ Latex ☐ Nickel ☐ Penicillin
☐ Other_____

Have you ever or are you currently taking bisphosphanates (e.g. Fosomax, Boniva, Acetonel)? ☐ Yes ☐ No

Please check "Yes" or "No"

☐ Yes	☐ No	Cardiovascular disease/heart problems
☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Artificial bone transplants or implants
☐ Yes	☐ No	Autism Spectrum disorder
☐ Yes	☐ No	Emotional/Nervous/Psychiatric care
☐ Yes	☐ No	Rheumatic fever/Scarlet fever
☐ Yes	☐ No	Low blood pressure
☐ Yes	☐ No	Blood/bleeding disorder
☐ Yes	☐ No	Severe or frequent headaches
☐ Yes	☐ No	Fainting spells/convulsions
☐ Yes	☐ No	Hepatitis, Liver Disease, or Jaundice
☐ Yes	☐ No	Organ transplant/replacement
☐ Yes	☐ No	Ear/Sinus trouble
☐ Yes	☐ No	Endocrine problems
☐ Yes	☐ No	Tonsils or adenoids removed
☐ Yes	☐ No	Arthritis/Joint swelling
☐ Yes	☐ No	Lung disease (TB, Emphysema)
☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Kidney problems
☐ Yes	☐ No	Blood transfusion
☐ Yes	☐ No	Tumors, Malignancies, or Cancer
☐ Yes	☐ No	Skin disease
☐ Yes	☐ No	Herpes
☐ Yes	☐ No	HIV Positive

For women: *Please check "Yes" or "No"*

☐ Yes	☐ No	Currently pregnant?

DENTAL HISTORY

Dentist:_____
Dentist's City:_____
Dentist's Phone:_____
How long with current dentist?_____
Date of last visit:_____

Do any of the following apply? *Please check "Yes" or "No"*

☐ Yes	☐ No	Clenching or grinding of your teeth
☐ Yes	☐ No	Smoking
☐ Yes	☐ No	Mouth breathing
☐ Yes	☐ No	Snoring
☐ Yes	☐ No	Currently sucking thumb or finger
☐ Yes	☐ No	History of sucking thumb or finger
☐ Yes	☐ No	Wear a nightguard
☐ Yes	☐ No	Sleep apnea
☐ Yes	☐ No	Had a sleep study
☐ Yes	☐ No	Use a CPAP breathing machine

Please check "Yes" or "No"

☐ Yes	☐ No	Sensitivity to cold, heat, sweets, or pressure
☐ Yes	☐ No	Bleeding gums when brushing or flossing
☐ Yes	☐ No	Clicking or popping jaw joint
☐ Yes	☐ No	Tongue or mouth piercing
☐ Yes	☐ No	History of trauma to head, face, jaws, or teeth
☐ Yes	☐ No	Pain in muscles of face or neck
☐ Yes	☐ No	TMJ pain or locking when opening or closing jaw
☐ Yes	☐ No	TMJ treatment
☐ Yes	☐ No	Ringing in the ears or dizziness
☐ Yes	☐ No	Speech problems
☐ Yes	☐ No	Missing or extra permanent teeth
☐ Yes	☐ No	Teeth removed by extraction
☐ Yes	☐ No	Tongue thrust
☐ Yes	☐ No	Gum surgery
☐ Yes	☐ No	Difficulty chewing or swallowing food

Is there any other information that might be important for us to know?

_____
_____
_____

Contact in case of emergency (other than parent, if child):
Name: _____
Phone:_____
Relationship to patient: ☐ Spouse ☐ Grandparent
☐ Friend ☐ Other:_____