Fairfield ORTHODONTICS

1411 OLIVER RD. STE 330
FAIRFIELD, CA 94534
(707) 428-3200

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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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:_____