Welcome and thank you for choosing our practice for your orthodontic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

(Please Print)

Name_____Date_____Social Security #_____
First MI Last

Address_____City_____State_____Zip_____

Sex: ☐ Female ☐ Male Birthdate_____ E-Mail_____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐Partnered for ___ years

Patient Employer/School _____ Occupation_____

Employer/School Address _____City_____ State_____ Zip_____

Spouse or parentôs name _____ Employer _____ Work Phone (___) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (___) _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____ Phone (___) _____

Address _____City _____ State _____ Zip _____

Name of Employer _____ Work Phone (____) _____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security #_____ Date employed _____

Name of employer _____Work Phone (____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual benefit? _____

SECONDARY INSURANCE INFORMATION

DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____Relationship to patient _____

Birthdate _____ Social Security # _____ Date of Employed _____

Name of employer _____ Work Phone (____) _____

Address _____ City _____State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual benefit?_____

DENTAL HISTORY

Patient Name _____ Age _____ Date of last Exam _____

Dentist _____ Date of last dental exam/cleaning _____

Reason for todayôs visit _____Specific Concern:_____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

MEDICAL HISTORY

Physician _____ Date of last visit _____

Please list all medications you are currently taking: _____

Allergies: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following:

☐ AIDS
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
Describe_____
☐ Hemophilia
☐ Hepatitis
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV Positive
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet/Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

Have you ever taken any of these medications?

Diet Medications: ☐ Dexfenfluramine ☐ Fen-phen ☐ Pondimin ☐ Redux

Blood Thinners: ☐ Coumadin ☐ Warfarin

Other: ☐ Levoxyl ☐ Synthroid

CERTIFICATION & ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to **Dr. Regalado** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient