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Kai Orthodontics

www.KaiOrtho.com

Please fill out this form completely, it is important for your orthodontic care.

Patient Information

Today's Date: _____

Name: _____ M F
Last First MI

Birthdate: ____/____/____ Age: ____ SS#: _____

Home Address: _____

City State Zip

Single Married Divorced Widowed Separated

Hm #: (____) _____ Cell #: (____) _____

Wk #: (____) _____ DL #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

City State Zip

How long there? _____ Occupation: _____

What time is best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Dentist Name: _____

Previous or Present (Please Circle) Date of last visit? _____

Insurance Information

PRIMARY

Orthodontic Coverage? Y N Dental Coverage? Y N

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

SECONDARY

Orthodontic Coverage? Y N Dental Coverage? Y N

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (____) _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

City State Zip

Responsible Party (if patient is a minor)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate ____/____/____ Financial Institution _____

Employer _____ Work Phone _____ S.S.#/SIN _____

Continued on Back

Medical History

Do you have a personal physician? Y N

Physician's Name: _____

Ph #: (____) _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Y N

Please explain: _____

Do you smoke or use tobacco in any other form? Y N

Have you had any metal rods, pins or implants? Y N

Are you taking any prescription/over-the-counter drugs? Y N

Please list each one: _____

If so, when? _____

Have you ever had any of the following diseases or medical problems

- | | |
|------------------------------------|---------------------------------|
| Y N Abnormal Bleeding/Hemophilia | Y N Herpes/Fever Blisters |
| Y N AIDS | Y N High Blood Pressure |
| Y N Alcohol / Drug Abuse | Y N HIV |
| Y N Anemia | Y N Hospitalized for Any Reason |
| Y N Arthritis | Y N Kidney Problems |
| Y N Artificial Bones/Joints/Valves | Y N Liver Disease |
| Y N Asthma | Y N Low Blood Pressure |
| Y N Blood Transfusion | Y N Lupus |
| Y N Cancer/Chemotherapy | Y N Mitral Valve Prolapse |
| Y N Colitis | Y N Pacemaker |
| Y N Congenital Heart Defect | Y N Psychiatric Problems |
| Y N Diabetes | Y N Radiation Treatment |
| Y N Difficulty Breathing | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema | Y N Seizures |
| Y N Epilepsy | Y N Shingles |
| Y N Fainting Spells | Y N Sickle Cell Disease/Traits |
| Y N Frequent Headaches | Y N Sinus Problems |
| Y N Glaucoma | Y N Stroke |
| Y N Hay Fever | Y N Thyroid Problems |
| Y N Heart Attack/Surgery | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers |
| Y N Hepatitis | 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 Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry/Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex | Y N Other |

List any other drugs/material allergies: _____

WOMEN: Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: _____

Are you nursing? Y N

Have you ever taken Bisphosphonates (e.g. Fosamax, Boniva)? Y N

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally reviewed the medical/dental information with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

Dental History

What would you like orthodontics to accomplish?

Have you ever had or been evaluated for orthodontic treatment? Y N

Have you ever had a serious / difficult problem associated with any previous dental work? Y N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Y N

Your current dental health is: Good Fair Poor

Do you still have wisdom teeth? Y N

Do you have any missing or extra permanent teeth? Y N

Have you ever had an injury to your: Mouth Teeth Chin None

Do you have any speech problems? Y N

Do you have any sleep problems?
 Sleep apnea Snoring Other None

Do you have any oral (mouth) habits? Y N

Do you like your smile? Y N

If not, what would you change? _____

We have the right to refuse service/treatment to anyone. If you and/or the patient fail to fully complete this form, refuse to sign, or alter this form in anyway, our office may choose to deny you our services/treatment.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

SIGNATURE _____

DATE _____

If this office accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE _____

DATE _____