**LUIS J. RODRIGUEZ, D.M.D, M.S.**
**ORTHODONTIST**

**CHECK ONE:**
**Private Insurance: ____**
**HMO: ____**
**Medicaid ____**
**No Insurance: ____**
**Other: ____**

**ORTHODONTIC PATIENT INFORMATION:**

Date _____

Patient's name: _____ Nickname: _____
Date of Birth: _____ Age: _____ Sex: _____ Social Security # _____
Address _____
Street City Zip
Telephone Home: _____ Cell: _____ Work: _____ Other:_____
Email:_____

**PERSON RESPONSIBLE FOR ACCOUNT:**

Name: _____ Relationship to patient: _____ SS#: _____

Address: _____
Street City Zip
Date of Birth: _____Telephone ( Home): _____Cell: _____ Work:_____

Employer_____ Occupation _____

**SECOND PERSON RESPONSIBLE FOR ACCOUNT:**

Name: _____ Relationship to patient: _____ SS#: _____

Address: _____
Street City Zip
Date of Birth: _____ Telephone (Home): _____ Cell: _____ Work: _____

Employer_____ Occupation _____

**DENTAL INSURANCE INFORMATION**

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Insured's DOB: _____

Insurance Co. Address: _____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Insured's DOB: _____

Insurance Co. Address_____ Phone No. _____

Reason for Orthodontic Consultation: _____

Referred by: _____

Family Dentist: _____ Telephone: _____

Last dental visit: _____

**MEDICAL HISTORY**

Is the patient health: Poor _____ Regular _____ Good _____ Excellent _____
Physician _____ Phone_____ Date of Last complete physical exam:_____
Is the patient taking any medication? _____

Is the patient allergic to any medication? _____
Does the patient have a tendency towards colds, sore throats or ear infections?_____
Have the tonsils and adenoids been removed? _____
Birth defects: _____
Has the patient reached puberty? _____ Girls: Has she started menstruation? _____
Boys: has his voice changed ? _____
Is the patient presently under the care of a physician for Illness?_____
Does the patient have any history of major illness? _____
Is the patient pregnant? _____

**CIRCLE** (Yes) or (No) If the patient has or has had any of the following:

| | | | |
|---|---|---|---|
| Asthma | Y N | Diabetes | Y N |
| Anemia | Y N | Dizziness | Y N |
| Arthritis | Y N | Epilepsy | Y N |
| Abnormal Bleeding | Y N | Hay Fever | Y N |
| Bone Disorders | Y N | Heart Murmur | Y N |
| Blood transfusion | Y N | Heart Problems | Y N |
| Bronchitis | Y N | Herpes | Y N |
| Bowel Syndrome | Y N | Hepatitis/ Liver problems | Y N |
| Congenital Heart Defect | Y N | High/ Low blood pressure | Y N |
| Convulsions | Y N | HIV / AIDS | Y N |
| Joint replacements | Y N | Stroke | Y N |
| Hyperactivity | Y N | Kidney problems | Y N |
| Pneumonia | Y N | Ulcer | Y N |
| Persistent cough | Y N | Rheumatic Fever | Y N |
| Scarlet Fever | Y N | Mental or nervous disorder | Y N |
| Tumor or Cancer | Y N | Problems with Immune system | Y N |
| Sexually transmitted disease | Y N | Sinus problems | Y N |

Has the patient ever been told by a physician that he or she needs to PREMEDICATE before dental treatment? _____
Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

**DENTAL HISTORY**

Has the patient had any orthodontic evaluation or treatment before?_____
Name of the orthodontist:_____
How many times does the patient brushes his/ her teeth?_____
Have there been any injuries to the face, mouth or teeth?_____
Has the patient ever sucked their finger or thumb?_____ Until what age?_____
Does the patient have any speech problems?_____
Is the patient a mouth breather while awake or asleep?_____
Has the patient been informed of any missing or extra permanent teeth? _____
Does the patient have any clicking or discomfort of the jaw joints? _____
Does the grind his/ her teeth? _____ Day or Night? _____
Does the patient play musical instruments with the mouth? _____

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Luis J. Rodriguez to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Patient Name: _____ Date: _____

Parent Signature: _____ Date: _____

Updates (date & initial):_____