Pearland Orthodontics

Practice Limited to Orthodontics and Dentofacial Orthopedics

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Welcome !

Your Smile Brightens Our Day!

Please fill out this form completely to the best of your ability. The better we communicate, the better we can care for you. All patient records are kept strictly confidential.

Today's Date _____

Tell Us About Yourself

Your Name_____
Last First MI
DOB _____/_____/_____ AGE _____ SS#_____

Home # (_____)_____-_____ Wk# (_____)_____-_____

Cell #(_____) _____-_____ Email _____

Home Address: _____

_____

Employer_____
Employer Address_____
_____
Occupation_____

Whom may we thank for referring you?
_____

Other family members seen by us_____

Spouse Information

His/Her name_____
Employer_____
Work # (____)_____-_____ Cell #(____)_____-_____

Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?
His/Her name _____
Work # (_____)_____-_____

Person Responsible for Account

Name:_____ Relationship_____
Billing Address _____
_____
Home #(____)____-_____ Wk #(____) _____-_____
SS#_____-____-_____
Employer _____
Employer Address _____

Primary Orthodontic Insurance

Orthodontic Coverage? Y_____ N_____
Insurance Co. Name_____
Insurance Co. Phone #(____)_____-_____
Insurance Co. Address_____
_____
Group # (Plan, Local, or Policy)_____
Policy Holder's Name_____
Relationship to Patient_____
Policy Holder's DOB_____SS#_____
Policy Holder's Employer_____
Employer's Address_____
_____

Secondary Orthodontic Insurance

Orthodontic Coverage? Y_____ N_____
Insurance Co. Name_____
Insurance Co. Phone #(____)_____-_____
Insurance Co. Address_____
_____
Group # (Plan, Local, or Policy)_____
Policy Holder's Name_____
Relationship to Patient_____
Policy Holder's DOB_____SS#_____
Policy Holder's Employer_____
Employer's Address _____
_____

Medical History

Do you have a personal physician? Y _____ N _____
Physician's Name:_____
Phone #(____) _____-_____ Date of last visit?____/____/____
Your current physical health? ___Good ____Fair ____Poor

Are you currently under the care of a physician? Y ____ N ____
Please explain: _____
_____

Are you taking any prescription/over-the-counter drugs?
Y ____ N____ If yes, please list:_____
_____

For women, are you pregnant? Y ___ N ___ Week #_____

CONTINUE ON BACK

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N Anemia/Radiation Trmt.
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur/Prosthetic Valve/Prosthetic Hips
Y N Heart Surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Hospital Stays
Y N Kidney/Liver Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headache
Y N Shingles
Y N Sinus Problems
Y N Tuberculosis
Y N Ulcers/Colitis

Please list any medical conditions that you have ever had:
_____
_____
_____

Are you allergic to any of the following:
Y N Aspirin
Y N Metals or Plastics
Y N Codeine
Y N Penicillin
Y N Other:_____
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Tetracycline

List any other drugs that you are allergic to: _____
_____

Habits:_____

_____

Dental History

Name of Dentist:_____
Last First
Phone #(_____)_____-_____
Date of Last Visit: _____/_____/_____
Date of Last Dental X-Rays taken___/___/___

What are the main concerns that you would like orthodontics to accomplish?
_____
_____

Have you ever had or been evaluated for orthodontic treatment before? Y____ N _____

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

Have you ever had an injury to your:
___Face ___Mouth ___Teeth ___Chin

Do you now or have you ever experienced pain/tenderness in your jaw joint (TMJ?TMD)?
Y____ N_____

Do you like your smile? Y____ N _____

Gums ever bleed? Y _____ N _____

Do you generally breathe through your mouth?
Y ___ N ____ If yes, please circle:
While awake? While asleep?

Do you need to take antibiotics before dental procedures? Y ____ N _____

Your current dental health is:
_____Good _____Fair _____Poor

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature **Date**

I understand that I am responsible for full payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

_____
Signature **Date**

Medical History Reviewed by_____
Sheela Kudchadker,DDS,MS,PA

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