

# 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 \_\_\_\_\_

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

Please list any medical conditions that you have ever had:

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any of the following:

- |                        |                        |
|------------------------|------------------------|
| Y N Aspirin            | Y N Dental Anesthetics |
| Y N Metals or Plastics | Y N Erythromycin       |
| Y N Codeine            | Y N Latex              |
| Y N Penicillin         | Y N Tetracycline       |
| Y N Other:             | _____                  |

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**