ALPAN ORTHODONTICS
Dr. David Alpan and Associates

PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's Name _____ (LAST) _____ (FIRST) _____ (INITIAL) Age _____ Patient's Birthday _____

○ Male ○ Female If patient is a minor, give name of patient or legal guardian _____

Relationship _____ Residence Address _____ (STREET) _____ (CITY) _____ (ZIP)

For how long? ○ Own ○ Rent

Patient is: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Minor Email _____

Driver's License No. _____ Social Security No. _____ Resp. Phone _____

What is your main concern about your smile or bite? _____ Cell Phone _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET) _____ (CITY) _____ (ZIP) Bus. Phone _____

Spouse's Name _____ Driver's Licence No. _____ Soc. Sec. No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET) _____ (CITY) _____ (ZIP) Bus. Phone _____

Name of nearest relative not living with you _____ Realtionship _____

Complete Address _____ (STREET) _____ (CITY) _____ (ZIP) Res. Phone _____

☐ I have no physician

Name of Physician _____ (ADDRESS) _____ (CITY) _____ (TELEPHONE)

Name of Current Dentist/Orthodontist _____ (ADDRESS) _____ (CITY) _____ (TELEPHONE)

What is your primary concern about your teeth? _____

Expectations for this Appointment? _____

Do you wish to speak to the doctor privately? ○ Yes ○ No

Is this visit for Emergency Orthodontic Care ○ Yes ○ No If yes, explain: _____

School Children Attend _____ Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____ Telephone _____

Address _____ (STREET) _____ (CITY) _____ (ZIP) Cell Phone _____

Name of insurance company (primary insurance) _____

_____ (INSURED'S PERSON NAME) _____ (BIRTH DATE) _____ (RELATIONSHIP)

_____ (SOCIAL SECURITY NO.) _____ (NAME OF GROUP DENTAL PLAN) _____ (GROUP NO.)

_____ (PLAN NO.) _____ (NAME OF UNION) _____ (LOCAL)

Name of insurance company (secondary insurance) _____

_____ (INSURED'S PERSON NAME) _____ (BIRTH DATE) _____ (RELATIONSHIP)

_____ (SOCIAL SECURITY NO.) _____ (NAME OF GROUP DENTAL PLAN) _____ (GROUP NO.)

_____ (PLAN NO.) _____ (NAME OF UNION) _____ (LOCAL)

TERMS AND CONDITION

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency orthodontic services, or any orthodontic service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that orthodontic services furnished to me are charged directly to me and that I am personally responsible for payment of all orthodontic services. I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from my insurance companies and will credit such collections to my account. However, AO cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my Orthodontist benefits accruing to me under my policy. A bookkeeping fee of $50/month will be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date. I understand that the fee estimate listed for this orthodontic service can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request , by the Doctor and/or by his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I furthermore agree that the reasonable value or said services shall be billed unless objected to by me, in writing, within the time of paying thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I have read the above conditions of treatment and agree to their content.

Signature Date _____

10. Do you have or have you had any of the following: (Please circle **'Y'** for Yes or **'N'** for No - answer all conditions):

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your orthodontic condition, but they are all associated with proper oral health care.
Please answer each question. Check the appropriate box and/or circle **YES** or **No** where applicable.

MEDICAL HISTORY

1. Are you in good health? ○ Yes ○ No

2. Date of last physical examination _____

3. Are you now under the care of a physician? ○ Yes ○ No
If so, what is the condition being treated? _____

4. Have you ever had any serious illness or operation? ○ Yes ○ No
If so, what illness or operation? _____

5. Have you ever been hospitalized? ○ Yes ○ No
If so, what was the problem? _____

6. Are you taking any ☐ medication, ☐ drugs or ☐ herbs? ○ Yes ○ No
If so, what? _____ What dosage? _____

7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ○ Yes ○ No If so, what? _____

8. Have you ever been pre medicated with antibiotics for your dental treatment? ○ Yes ○ No

9. Are you sensitive or allergic to any drugs or materials? ○ Yes ○ No

☐ Penicilin, ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other

○ Y ○ N	Snoring	○ Y ○ N	Sinus Trouble	○ Y ○ N	Cortisone Medicine
○ Y ○ N	Sleep Apnea	○ Y ○ N	Heart Murmur	○ Y ○ N	Allergies to Metals
○ Y ○ N	Anemia	○ Y ○ N	Blood Disease	○ Y ○ N	Excessive Bleeding
○ Y ○ N	Herpes	○ Y ○ N	Heart Ailments	○ Y ○ N	Mitral Valve Prolapse
○ Y ○ N	Stroke	○ Y ○ N	Heart Attack	○ Y ○ N	High Blood Pressure
○ Y ○ N	Ulcers	○ Y ○ N	Cerebral Palsy	○ Y ○ N	Low Blood Pressure
○ Y ○ N	Diabetes	○ Y ○ N	Drug Addiction	○ Y ○ N	HIV Related Complex
○ Y ○ N	Arthritis	○ Y ○ N	Kidney Disease	○ Y ○ N	Respiratory Disease
○ Y ○ N	Asthma	○ Y ○ N	Chemotherapy	○ Y ○ N	Epileosy or Seizures
○ Y ○ N	Cancer	○ Y ○ N	Stomach Ulcers	○ Y ○ N	Psychiatric Treatment
○ Y ○ N	Seizures	○ Y ○ N	Angina Pectoris	○ Y ○ N	Hepatitis or Jaundice
○ Y ○ N	Hay Fever	○ Y ○ N	Mental Disorder	○ Y ○ N	Difficulty Swallowing

○ Y ○ N	Headaches	○ Y ○ N	Thyroid Disease	○ Y ○ N	Congenital Heart Lesions
○ Y ○ N	Implant (s)	○ Y ○ N	Fainting Spells	○ Y ○ N	Osteoporosis
○ Y ○ N	Glaucoma	○ Y ○ N	Rheumatic Fever	○ Y ○ N	X-Ray or Cobalt Treatment
○ Y ○ N	Tonsillitis	○ Y ○ N	Tuberculosis (T.B.)	○ Y ○ N	Radiation Treatment of any kind
○ Y ○ N	Hemophilia	○ Y ○ N	Blood Transfusion		
○ Y ○ N	Cold Sores	○ Y ○ N	Low Blood Sugar	○ Y ○ N	Venereal Disease (Syphilis, Gonorrhea)
○ Y ○ N	Emphysema	○ Y ○ N	Joint Replacement		
○ Y ○ N	Rheumatism	○ Y ○ N	Nervous Disorders	○ Y ○ N	Acquired Immune Deficiency Syndrame (AIDS)
○ Y ○ N	Chicken Pox	○ Y ○ N	Tumors or Growths		
○ Y ○ N	Bruise Easily	○ Y ○ N	Allergies or Hives	○ Y ○ N	TMJ (Temporomandibular Joint) Disorder
○ Y ○ N	Head Injuries	○ Y ○ N	Pain in Jaw Joints		
○ Y ○ N	Heart Failure	○ Y ○ N	Artificial Prosthesis		
○ Y ○ N	Scariel Fever	○ Y ○ N	Sickle Cell Disease		

○ Y ○ N Other _____

11. Do you have any disease, condition or problem not listed that you think we should know about? ○ Yes ○ No

If so, what? _____

12. Do you wear a cardiac pacemaker, or have you had heart surgery? ○ Yes ○ No

13. Do you smoke? If yes, how much? _____ ☐ Cigarettes, ☐ Cigars ☐ Packs per day ○ Yes ○ No

14. Have you ever taken the drugs? ○ Yes ○ No

☐ Fen-phen, ☐ Redux, ☐ Fosamax(Bisphosphonate), ☐ Zometa, ☐ Actonel, ☐ Boniva, ☐ Aredia, ☐ Diet Drugs?

15. (Women) Are you pregnant? If so how many months? _____ ○ Yes ○ No

16. (Women) Do you have any problems associated with your menstrual period? ○ Yes ○ No

17. (Women) Do you take any birth control medication and hormones? ○ Yes ○ No

DENTAL HISTORY

1. Have you ever had Orthodontic Treatment? ...if so, Date? _____ ○ Yes ○ No

2. Have you ever been recommended Orthodontic Treatment? ...if so by whom? _____ ○ Yes ○ No

3. Have you completed all your dental work? or is there more work planned for the future? ○ Yes ○ No

If so, explain? _____

4. How long since your last full mouth X-Rays? Weeks _____ Months _____ Years _____

5. How long since your last dental treatment? Weeks _____ Months _____ Years _____

6. Does dental treatment make you nervous? ☐ Slightly, ☐ Moderately ☐ Extremely ○ Yes ○ No

7. Are you currently wearing any dental removeable devices? ...if so, Explain ? _____ ○ Yes ○ No

8. What is it about your smile you would like to improve? _____

☐ I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way.

Patient refused / was unable to sign because: _____

☐ I have received a copy of the **Dental Materials Fact Sheet** as required by law.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date _____ Signature _____

Reviewed by _____ Lic # _____ Date _____

B UPDATE - Since your last visit A :

1. Have you seen a medical doctor? ○ Yes ○ No
2. Have you had a change in your medication? ○ Yes ○ No
3. Have you had a change in your medical condition or had surgery? ○ Yes ○ No

Please note changes in health since last visit. If no changes, please write "None"

C UPDATE - Since your last visit B :

4. Have you seen a medical doctor? ○ Yes ○ No
5. Have you had a change in your medication? ○ Yes ○ No
6. Have you had a change in your medical condition or had surgery? ○ Yes ○ No

Please note changes in health since last visit. If no changes, please write "None"

Date _____ Signature

Date _____ Signature

REVIEWED BY

A

_____

Date _____

B

_____

Date _____

C

_____

Date _____

DO NOT WRITE IN THIS SPACE

	A	B	C
DATE			
B.P			
PULSE			
TEMP			
DATE			
BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse here of:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed Date _____ Relationship to patient _____

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Submit