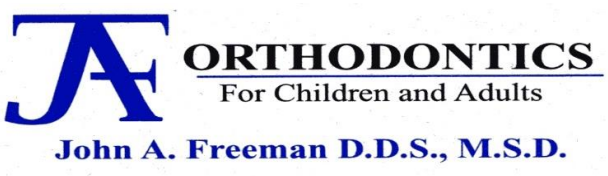

Welcome to our practice . . . please tell us about yourself!

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) :	PREFERRED FIRST NAME:	BIRTHDATE:	GENDER:
STREET ADDRESS:	CITY:	ZIP:	PHONE NUMBER:
IN CASE OF EMERGENCY, PLEAST NOTIFY: NAME: PHONE NUMBER: RELATION:		EMAIL ADDRESS:	
HOW DID YOU HEAR ABOUT US, OR WHO MAY WE THANK FOR REFERRING YOU? ASK US ABOUT OUR REFERRAL PROGRAM!			
DENTIST'S NAME:	LAST VISIT: (approximate)	PHYSICIAN'S NAME:	LAST VISIT: (approximate)
FREQUENCY OF DENTAL CHECKUPS: (EX: ONCE OR TWICE A YEAR, ONLY IF PROBLEM, NEVER)			HOW OFTEN DO YOU FLOSS?

Work Information:

MAY WE CALL YOU AT WORK?	WORK PHONE NUMBER:
OCCUPATION:	EMPLOYER:
WORK ADDRESS:	
CITY: STATE: ZIP:	
HOW LONG HAVE YOU WORKED THERE?	

Spouse or Second Responsible Party:

NAME: (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP TO PATIENT:
STREET ADDRESS: (IF DIFFERENT)	
PHONE NUMBER:	EMAIL ADDRESS:
EMPLOYER:	OCCUPATION:
WORK ADDRESS:	

Dental Insurance Information:

D.O.B. OF RESPONSIBLE PARTY:	SOCIAL SECURITY NUMBER:	D.O.B. OF RESPONSIBLE PARTY:	SOCIAL SECURITY NUMBER:
INSURANCE COMPANY NAME:	GROUP #: (IF KNOWN)	INSURANCE COMPANY NAME:	GROUP #: (IF KNOWN)
INSURANCE COMPANY STREET ADDRESS:		INSURANCE COMPANY STREET ADDRESS:	
CITY: STATE: ZIP:		CITY: STATE: ZIP:	
INSURANCE COMPANY PHONE NUMBER:		INSURANCE COMPANY PHONE NUMBER:	

Health and Dental History

1. Do you have any health problems? ◯ Yes ◯ No

2. Are you under treatment by a physician? ◯ Yes ◯ No

3. Are you currently taking any medication? ◯ Yes ◯ No

4. Are you sensitive or allergic to anything, or had a bad reaction to medicine? ◯ Yes ◯ No

5. Have you ever been hospitalized? ◯ Yes ◯ No

6. Have you ever had a thumb sucking habit? ◯ Yes ◯ No

7. Have you had any previous orthodontic treatment? ◯ Yes ◯ No

8. Have any members of your family (brothers, sisters, parents) had orthodontic treatment? ◯ Yes ◯ No

9. Have there been any relatives that had a prominent lower jaw and "underbite" or a very short lower jaw and "overbite" on either side of your family? ◯ Yes ◯ No

10. Do you have difficulty chewing or swallowing? ◯ Yes ◯ No

11. Do you experience noise, pain, or difficulty with movement in the jaw? ◯ Yes ◯ No

12. Are you planning to move from San Luis Obispo County in the next 3 years? ◯ Yes ◯ No

13. Have you had any of the following? (Check all that apply)

- ◯ Heart trouble or congenital heart lesions
- ◯ Replacement heart valve or replacement joint
- ◯ Rheumatic Fever
- ◯ Asthma or other lung disorders
- ◯ Tuberculosis
- ◯ Skin rash or hives
- ◯ Diabetes
- ◯ Stomach disorders
- ◯ Hormone disorders
- ◯ Thyroid abnormalities
- ◯ Hepatitis or other liver disorders
- ◯ Kidney Disorders
- ◯ Blood or bleeding disorders
- ◯ Anemia
- ◯ Epilepsy
- ◯ Nervousness or Dental Anxiety
- ◯ Fainting or dizziness
- ◯ Other_____

Doctor Notes: