15595 Los Gatos Blvd
Suite B
Los Gatos, CA 95032
Tel 408.884.8969
www.ESortho.com

WELCOME TO OUR PRACTICE!

Please take a few minutes to complete the following information so we can better care for your orthodontic needs.

Today's Date ____________ **CHILD (UNDER 18) HEALTH HISTORY**

PATIENT INFORMATION

Patient's Name__________________________________ Birthdate__________ Age _____ ☐Male ☐Female
Home Address _______________________________________ Home Phone________________
City ______________________________ State _______ Zip __________ Mobile Phone________________
School____________________________ City____________ Grade _________ Email ________________
Sister(s)/Age(s) ____________________________ Brother(s)/Age(s) ____________________________

PARENTS / GUARDIANS

Name/Relationship____________________________ Name/Relationship ____________________________
Email ____________________________________ Email ____________________________________
Address __________________________________ Address __________________________________
City __________________State ______ Zip _______ City __________________State ______ Zip ______
Occupation ________________________________ Occupation ________________________________
Employer __________________________________ Employer __________________________________
Business Phone _____________________________ Business Phone _____________________________
Mobile Phone _______________________________ Mobile Phone _______________________________
Has any other member of the family been a patient at this office? Names:
________________________________ Who may we thank for referring you?__________________________
In case of emergency, who should we contact? ___________________________ Phone _________________

PATIENT MEDICAL HISTORY

Physician's Name ____ Date of Last Visit ___________________
Is the patient currently under medical treatment?_______ Is the patient taking any medications? _______________
Has the patient ever had any serious illness and/or operations? ____________________________________
Has the patient had allergic reactions to any drugs or medications? _____ If yes, which ones?________________
Does the patient have allergies to nickel or latex? ___________ (Women only) Is the patient pregnant? ___________
Please check the box for each medical condition that applies:

☐Hyperactivity (ADD/ADHD)	☐Reports of grinding teeth	☐Snoring	☐Restless sleep
☐Bed wetting	☐Mouth breathing	☐Sinus Problems	☐Frequent Colds
☐Asthma/Hay Fever	☐Tonsils/Adenoids Removed	☐Mood swings	☐Loss of interests
☐Sleep Study conducted	☐Frequent Headaches	☐Epilepsy	☐Cancer
☐Speech impairment	☐Bone Disorders	☐High Blood Pressure	☐Diabetes
☐Fainting/Dizzy Spells	☐Artificial Heart Valves	☐Heart Problems	☐Bleeding Excess
☐Kidney Disease	☐Liver Disease	☐Motor Difficulties	☐Stroke
☐Nervous Problems	☐Pneumonia	☐Radiation Treatment	☐Stomach Ulcer
☐Thyroid Problems	☐Arthritis/Rheumatism	☐Tuberculosis	☐Hearing Issues

☐Other ____

OVER →

Patient Name ________________________________

PATIENT DENTAL HISTORY

Dentist's Name ____ Date of last visit ____________________
Date of last complete full mouth X-rays and/or Panorex X-ray ____
Please check the box for all that apply:

☐ Bleeding Gums ☐ Blisters on Lips/Mouth ☐ Prone to Cavities ☐ Missing Teeth
☐ Extra Teeth ☐ Any Teeth Extracted ☐ Chewing Difficulties ☐ Speech Difficulties
☐ Tooth Grinding/Clenching ☐ Severe Head and/or Facial Injuries____________
☐ Pain or Clicking in the Jaw Joint (TMJ/TMD)
☐ Jaw Locking on Opening or Closing _____________

Have you ever consulted with an orthodontist? If so, when? ____________
Have you ever had orthodontic treatment? If so, when? ____
Would you mind wearing braces to straighten your teeth? _________
What would you like orthodontic treatment to accomplish? ____
What concerns you most about orthodontic treatment?

☐ Cost ☐ Appearance ☐ Length of Time ☐ Pain ☐ Effectiveness ☐ Other ____________

PRIMARY DENTAL INSURANCE

Person responsible for account (Last, First, MI) ____
Relationship to patient ________________ Birthdate _______________ Soc. Security # ____________________
Address ____
City ____________________________ State ______ Zip _________ Home Phone _______________________
Responsible party employed by _____________________________ Business Phone ______________________
Business Address ____ Occupation ______________________
Insurance Company ____________________________________ Insurance Phone ______________________
Insurance Company Address ____
Subscriber ID # ____ Group #______________________

ADDITIONAL DENTAL INSURANCE

Insured Name (Last, First, MI) ____
Relationship to patient __________________ Birthdate ______________ Soc. Security # ____________________
Address ____
City ____________________________ State ______ Zip _________ Home Phone _______________________
Insured employed by ____________________________________ Business Phone _________________________
Insurance Company ____________________________________ Insurance Phone ________________________
Insurance Company Address ____
Subscriber ID # ____ Group # _______________________

HIPAA COMPLIANCE DISCLOSURE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by the OSHO, the CDC, and the ADA.

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. I authorize release of any information regarding my treatment to my dental/medical insurance company. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical/dental health

Signature ____ _____Date ________________________________