444 S. BRAND BOULEVARD, SAN FERNANDO, CA 91340
(818) 365-9827 FAX (818) 365-8956

PATIENT INFORMATION

Date .... Male ❑ Female ❑

Patient's Name ....
Last First Middle

Address ....
Street City State Zip

Home Phone ( ) .... Birthdate .... Age .... Social Security # ....

E-mail Address: ....

If patient is a minor, give parent's or guardian's name ....
Last First Middle

Who may we thank for referring you to our office? ....

RESPONSIBLE PARTY INFORMATION

Name ....
Last First Middle

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Residence ....
Street City State Zip

How long at this address .... Home Phone ( ) .... Work Phone ( ) ....

Previous Address (if less than 3 yrs.) ....
Street City State Zip

Social Security # ....Birthdate .... Relationship to Patient ....

Employer .... Occupation .... No. Years Employed ....

Employer Address ....
Street City State Zip

Spouse's Name ....
Last First Middle

Employer .... Occupation .... No. Years Employed ....

Employer Address .... Work Phone ( ) ....
Street City State Zip

Social Security # .... Birthdate .... Relationship to Patient ....

INSURANCE INFORMATION

Insured's Name .... Insured's Social Security # ....

Insurance Company .... Group No .... Local No ....

Insurance Co. Address ....

Do you have dual coverage? ❑ Yes ❑ No If yes:

Insured's Name .... Insured's Social Security # ....

Insurance Company .... Group No .... Local No ....

Insurance Co. Address ....

EMERGENCY INFORMATION

Name of nearest relative not living with you .... Telephone ( ) ....

Complete Address ....
Street City State Zip

General Dentist .... Physician ....

Signature (Parent's signature if minor) .... Date ....

Thank you for supplying the above information. PLEASE COMPLETE MEDICAL HISTORY FORM ON THE OTHER SIDE.

Member American Association of **Orthodontists**

MEDICAL HISTORY

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionaire and there may be additional questions concerning your health.

1. Are you in good health? ❑ yes ❑ no
2. Are you now under the care of a physician? ❑ yes ❑ no
   If so, what is the condition being treated? ______
3. Are you taking any medicine(s)? ❑ yes ❑ no
   If yes, what medicine(s) are you taking? ______
4. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease ❑ yes ❑ no
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ❑ yes ❑ no
   c. Allergy / asthma or hay fever ❑ yes ❑ no
   d. Sinus trouble ❑ yes ❑ no
   e. Fainting spells or seizures ❑ yes ❑ no
   f. AIDS or HIV infection ❑ yes ❑ no
   g. Epilepsy or other neurological disease ❑ yes ❑ no
5. Have you had abnormal bleeding? (bleed easy or bleeding hard to stop) ❑ yes ❑ no
6. Are you allergic to or have you had a reaction to:
   a. Local anesthetics ❑ yes ❑ no
   b. Penicillin or other antibiotics ❑ yes ❑ no
   c. Sulfa drugs ❑ yes ❑ no
   d. Aspirin ❑ yes ❑ no
   e. Iodine ❑ yes ❑ no
   f. Codeine or other narcotics ❑ yes ❑ no
   g. Latex ❑ yes ❑ no
   h. Other ❑ yes ❑ no
7. Have you taken Phen-Fen? ❑ yes ❑ no
8. Are you pregnant? ❑ yes ❑ no
9. Do you have any disease, condition or problem not listed above that you think I should know about? ❑ yes ❑ no
   If yes, explain ______

DENTAL HISTORY

1. Have there been any injuries to the face, mouth or teeth? ❑ yes ❑ no
   If yes, explain ______
2. Have you ever sucked a thumb or fingers? (until what age?______) ❑ yes ❑ no
3. Do you have any speech problems? ❑ yes ❑ no
   If yes, explain ______
4. Are you a mouthbreather while awake or asleep? ❑ yes ❑ no
5. Do you bite your nails, lip or tongue? ❑ yes ❑ no
6. Do you grind your teeth at night? ❑ yes ❑ no
7. Have you been informed of any missing or extra permanent teeth? ❑ yes ❑ no
8. Has an orthodontist been consulted previously? ❑ yes ❑ no
   If yes, who and when? ______
9. Have we treated any other family members? ❑ yes ❑ no
   If yes, who? ______

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Babayan, Dr. Wiedman, or any other member of this staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent, if a minor) ______ Date ______

Dentist (Orthodontist) Signature ______ Date ______

Updates (dates and initials) ......