ADULT FORM

Dr.		
Recs.	Date	Time
X-Ray	Date	Time

SANTA CLARITA ORTHODONTICS

Dr. Anthony Cha, D.D.S., M.S.

ORTHODONTICS and DENTOFACIAL ORTHOPEDICS

EXAM		
Month	Day	Year

1 Tell Us About Yourself

Name _____ (Last) _____ (First) _____ (Middle) _____ (Preferred Name)

_____ Male / _____ Female Birthdate: _____ Age: _____

Address: _____ (Address) _____ (City) _____ (Zip) Home Phone: _____

Family in treatment with us: _____

Whom may we Thank for referring you?

2

General Dentist: _____ Last Visit Date: _____

Address: _____ Phone #: _____

3 Employer Information

Employer: _____ Job Title: _____

Work #: _____ Fax # _____

How long at current job: _____ SS#: _____ DL#: _____

4 Spouse Information

Name: _____ Birthdate: _____

Employer: _____ Work # _____ Job Title: _____

How long at current job: _____ SS#: _____ DL#: _____

5 Marital Status

___ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Person (Not living with you) to contact in case of emergency

Name: _____ Relationship: _____ Phone #: _____

6 Primary Orthodontic Insurance

Insurance Co. Name: _____

Policy Owners Name: _____

Policy Owners Birthdate: _____

Policy Owners SS#: _____

7 Secondary Orthodontic Insurance

Insurance Co. Name: _____

Policy Owners Name: _____

Policy Owners Birthdate: _____

Policy Owners SS#: _____

Creating a Better World One Smile at a Time!

Dental History

Any injuries to head or mouth? _____ Any jaw clicking, locking or pain? _____

Have you ever had Orthodontic Treatment? _____ When: _____ Name of Orthodontist: _____

Have your "Wisdom Teeth" been removed? _____ When: _____ Name of Oral Surgeon: _____

What is your main concern: _____

Please check any of the following conditions that apply to you:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Chipped / Injured Teeth
- ☐ Cyst / Infection
- ☐ Dental Treatment in Progress
- ☐ Difficulty Breathing / Chewing
- ☐ Food Collection Between Teeth
- ☐ Frequent Cold Sores, Canker Sores
- ☐ Grinding Teeth or Clenching
- ☐ Jaw Fractures
- ☐ Loose Teeth or Broken Fillings
- ☐ Missing Teeth
- ☐ Mouth Breathing
- ☐ Nail Biting
- ☐ Periodontal Problems / Pockets
- ☐ Root Canals
- ☐ Sensitivity to Cold / Hot
- ☐ Teeth Irritating Cheek / Lips
- ☐ Thumb Habit To Age_____
- ☐ Tongue Habit, Swallowing Problems
- ☐ Any Permanent or Extra Teeth Removal

Medical History

Physician _____ Phone # _____ Last visit: _____

Please list all medications you are currently taking: _____ Have you ever taken Phen Fen: _____

Do you need to be Pre-Medicated? Y or N Why: _____ Have you had joint replacement: _____

(Women) Are you pregnant: _____ Nursing: _____ Taking Birth Control Pills _____

Allergies: _____ Medical Insurance: _____

(Foods / Medications / Latex Gloves / Unknown...)

Have you ever been hospitalized? Y or N Explain: _____

Please check any of the following conditions that apply to you:

- ☐ Accidents_____
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma or Hay Fever
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Bruises Easily
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Rehabilitation Drugs/Alcohol
- ☐ Circulatory Problems
- ☐ Diabetes / Blood Sugar
- ☐ Epilepsy
- ☐ Fainting – Seizures – Convulsions
- ☐ Glandular / Hormonal Problems
- ☐ Glaucoma
- ☐ Headaches - Severe
- ☐ Hearing Loss
- ☐ Heart Murmur
- ☐ Heart Problems
- Describe _____
- ☐ Hemophilia
- ☐ Hepatitis / Jaundice
- ☐ High or Low Blood Pressure
- ☐ HIV Positive / AIDS
- ☐ Jaw Pain
- ☐ Kidney or Bladder
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Mono
- ☐ Nervous / Hyperactive
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Severe Infections
- ☐ Shortness of Breath
- ☐ Speech or Learning Disorder
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

It is my responsibility to advise the office of any changes in Personal/Medical status: **Initials** _____

Are there any Psychological or Emotional Problems that should be brought to our attention: _____

Please sign that this information is accurate and complete:

Signature _____ Date _____

Received By Dr. _____ Date _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, handicaps or problems we might encounter? **Yes / No**