American Association of Orthodontists

Lisa Angelici, D.M.D., Inc.

Practice Limited to Orthodontics

18426 Brookhurst St., Ste. 204, Fountain Valley, CA 92708
(714) 847-2650

PLEASE PRINT

1 About You

Today's Date:_____

Name:_____
LAST FIRST MI MR MRS MS DR

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate:____/____/____ Age:_____ SS#:_____

Home Address:_____
APT/CONDO #

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #:(____)_____ Cell/Other#:(____)_____

WK #:(____)_____ Ext:_____ DL#:_____

Email Address:_____

Employer Name:_____

Employer's Address:_____

Occupation:_____

Where & when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

General Dentist Name:_____

Address:_____

Last Teeth Cleaning Date:_____

2 Spouse Information

His/Her Name:_____

Employer:_____ Occupation:_____

WK #:(____)_____ Ext:_____ SS#:_____

Birthdate:_____

Person Responsible for Account:_____

WK#:(____)_____ Ext:____ Cell/Other#:_____

Billing Address:_____

Relationship:_____ SS#:_____

Employer:_____ DL#_____

3 Orthodontic Insurance

Primary

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:(____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthday:____/____/____ SS#:_____

Insured's Employer:_____

Employer's Address:_____

_____

Secondary

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:(____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthday:____/____/____ SS#:_____

Insured's Employer:_____

Employer's Address:_____

_____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name:_____ Relation:_____

WK #:(____)_____ HM#:(____)_____

4 Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:_____

Phone#:(____)_____ Date of last visit:_____

CONTINUED ON BACK OF FORM

4 Medical History *continued*

Your current physical health is ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ No ❑ Yes

Please explain_____

Are you taking any prescription/over-the-counter drugs? ❑ No ❑ Yes

Please list each one_____

Have you ever had any of the following diseases or medical problems?

Y	N	Heart Attack/Stroke	Y	N	Psychiatric Problems
Y	N	Cancer/Chemotherapy	Y	N	Epilepsy/Seizures/Fainting Spells
Y	N	Heart Murmur	Y	N	Diabetes/Tuberculosis (TB)
Y	N	Rheumatic Fever	Y	N	Drug Alcohol Abuse
Y	N	HIV+/AIDS	Y	N	Venereal Disease
Y	N	Heart Surgery/Pacemaker	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Shingles	Y	N	Ulcers/Colitis
Y	N	Mitral Valve Prolapse	Y	N	Congenital Heart Defect
Y	N	Kidney Problems	Y	N	Anemia/Radiation Treatment
Y	N	Artificial Bones/Joints	Y	N	Asthma/Arthritis
Y	N	Artificial Valves	Y	N	Difficulty Breathing
Y	N	Sinus Problems	Y	N	Hospitalized for Any Reason
Y	N	High/Low Blood Pressure	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Blood Transfusion
Y	N	Severe/Frequent Headaches	Y	N	Emphysema/Glaucoma

Please list any medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following items?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Any Metal/Plastic
Y	N	Erythromycin	Y	N	Codeine	Y	N	Other

Please list any other drugs that you are allergic to:_____

_____

5 Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Have you ever been evaluated for or had orthodontic treatment?

❑ No ❑ Yes If yes Plelase Explain:_____

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ No ❑ Yes

Do you now or have you ever experienced any pain / discomfort in your jaw joint (TMJ / TMD)? ❑ No ❑ Yes

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ No ❑ Yes

Do your gums ever bleed? ❑ No ❑ Yes

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you have any speech problems?_____

_____

Do you generally breathe through your mouth? Y N Awake? Y N Asleep? (Please Circle One)

Do you have any missing or extra permanent teeth? ❑ No ❑ Yes

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I am aware that I am responsible for all cost of orthodontic treatment and may incur collection costs if not paid in full at the time of service.

_____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

This authorization is valid for 12 months from the date above.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Lisa Angelici, D.M.D., Inc.

_____

SIGNED (INSURED PERSON) DATE

This authorization is valid for 12 months from the date above.

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

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature Date

6 Thank you for filling out this form completely.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with the patient named herein. Initials_____ Date_____

Doctor's Comments:

_____

_____

_____

_____

Update HH. Date_____Initials_____ Date_____Initials_____

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18426 Brookhurst Street, Suite 204, Fountain Valley, CA 92708
Website: www.angelortho.com • Email: frontoffice@angelortho.com

PLEASE PRINT

1 Tell Us About Your Child

Today's Date:_____

Child's Name:_____
LAST FIRST MI

Nickname:_____

Child's Birthdate:____/____/____ Child's Age:_____

School:_____ Grade:_____

Child's Home #: (____)_____

Child's Home Address:_____
APT/CONDO #

_____
CITY STATE ZIP

2 Who is accompanying your child today?

Name:_____ Relation:_____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you?_____

Other family members seen by us:_____

_____

General Dentist Name:_____

Address:_____

Last Teeth Cleaning Date:_____

Parent's Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

If parents are separated/divorced, patient lives with:_____

3 Mother's Information: ❑ Mother ❑ Step Mother ❑ Guardian

Name:_____

WK #:(___)_____ Ext:_____ HM#:(___)_____

Employer:_____

Occupation:_____ DL#_____

SS#:_____ Date of Birth:_____

Cell/Other #:(___)_____ Email:_____

Father's Information: ❑ Father ❑ Step Father ❑ Guardian

Name:_____

WK #:(___)_____ Ext:_____ HM#:(___)_____

Employer:_____

Occupation:_____ DL#_____

SS#:_____ Date of Birth:_____

Cell/Other #:(___)_____ Email:_____

4 Person Responsible for Account

Name:_____

WK #:(___)_____ Ext:_____ HM#:_____

Billing Address:_____

Relationship:_____ SS#:_____

Employer:_____ DL#_____

5 Primary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:(____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthday:_____/_____/_____

SS#:_____

Insured's Employer:_____

Employer Address:_____

_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#:(____)_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relationship to Patient:_____

Insured's Birthday:_____/_____/_____

SS#:_____

Insured's Employer:_____

Employer Address:_____

_____

CONTINUED ON BACK OF FORM

6 What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

If yes please explain _____

Has there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played_____

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain / tenderness in his/her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does your child brush his/her teeth daily? ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician:_____

Phone #:(_____)_____ Date of Last Visit:_____

Is your child currently under the care of a physician? ❑ Yes ❑ No

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Please describe your child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is currently taking:_____

_____

Is your child allergic to any of the following items?

Y N	Penicillin	Y N	Tetracycline	Y N	Latex
Y N	Aspirin	Y N	Dental Anesthetics	Y N	Any Metal/Plastic
Y N	Codeine	Y N	Erythromycin	Y N	Other

Please list all drugs that your child is allergic to:_____

_____

7 Has your child ever had any of the following medical problems?

Y N	Allergic to Plastic	Y N	Allergic to Latex/Metals
Y N	Heart Murmur	Y N	Congenital Heart Defect
Y N	Cancer	Y N	Convulsions/Epilepsy
Y N	Diabetes	Y N	Abnormal Bleeding
Y N	Rheumatic Fever	Y N	Hearing Impairment
Y N	HIV+/AIDS	Y N	Any Operations
Y N	Hemophilia	Y N	Any stays in a hospital
Y N	Asthma	Y N	Kidney/Liver Problems
Y N	Hepatitis	Y N	Handicaps/Disabilities
Y N	Tuberculosis (TB)	Y N	Allergies to any Drugs

Please discuss any medical problems that your child has had:

_____

_____

8 Has your child ever had any of the following habits?

Y N	Thumb/Finger Sucking	Y N	Mouth Breather
Y N	Lip Sucking/Biting	Y N	Speech Problems
Y N	Clenching/Grinding Teeth	Y N	Nail Biting
Y N	Nursing Bottle Habits	Y N	Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am aware that I am responsible for all costs of orthodontic treatment and may incur collection costs if not paid in full at the time of service.

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Doctor's Comments:

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_____

_____

Update HH. Date_____Initials_____ Date_____Initials_____