The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

Welcome

To Your Neighborhood Orthodontist

LARRY KAWA, D.D.S.
ALEX BARBOSA, D.D.S.
SCOTT SPENCER, D.M.D.

Please fill out this form completely. The better we communicate, the better we can care for you.

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: _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm#: _____ **Cell #** _____

Wk#: _____ Ext: ____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last Visit Date: _____

2 Spouse Information

His / Her Name: _____

Employer: _____

WK#: _____ Ext: _____ SS# : _____

Birthdate: ___/___/___

3 Your Children

NAME OF CHILD	BIRTHDATE
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

Do they live with you? ☐ Yes ☐ No

4 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 Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

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 Birthdate: ___/___/___ Insured's SS #: _____

Insured's Employer: _____

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

His / Her Name: _____ Relation: _____

Wk#: _____ Hm#: _____

Person Responsible for Account: _____

Wk#: _____ Ext: _____ Hm#: _____

Billing Address: _____
ZIP

Relation: _____ SS#: _____

Employer: _____ DL#: _____

5 Medical History

Do you have a personal physician? ☐ **Yes** ☐ **No**

Physician's Name: _____

Phone #: _____ Date of last visit: _____

6 Medical History *continued*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

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

Please explain: _____

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

Please list each one: _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

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

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

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

_____

Are you allergic to any of the following?

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

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

_____

7 Dental History

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

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

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

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

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? _____

_____

Do you generally breathe through your mouth? ☐ Awake? ☐ Asleep?
(Please Check One)

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

8 References

Do you know of any other family member or friend who would benefit from orthodontic treatment? ☐ Yes ☐ No

Name	Phone Number
_____	_____
_____	_____

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held by the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

! Thank you for filling out this form completely.

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 the office, us the services of one or more credit reporting services.

_____
Signature Date

! Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments:

_____

_____

_____