

WELCOME TO TAN ORTHODONTICS

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely.
The better we communicate, the better we can care for you.

TODAY'S DATE: _____

1. Tell us about you

Name (Last, First, MI): _____

Mr. Mrs. Ms. Dr. Male Female

I preferred to be called: _____

Birthdate: ____ / ____ / ____ Age: ____ SSN: _____

Married Single Partnered Separated Divorced Widowed

Home address: _____

City, State, Zip: _____

Home phone: _____

Cell phone/pager/other: _____

Work phone (include ext.): _____

Drivers license number: _____

Email address: _____

Employer: _____

Employer's address: _____

City, State, Zip: _____

How long there? ____ Occupation: _____

Where and when is best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General dentist: _____

Date of last visit: _____

2. Spouse information

His or her name: _____

Birthdate: ____ / ____ / ____ Age: ____ SSN: _____

Employer: _____

Work phone (include ext.): _____

3. Account responsibility

Name: _____

Relation: _____ SSN: _____

Billing address: _____

City State Zip: _____

Employer: _____ DL#: _____

Work phone (include ext.): _____

Home phone: _____

4. Orthodontic Insurance

■ PRIMARY

Orthodontic coverage? Yes No

Dental coverage? Yes No

Insurance company name: _____

Their address: _____

Their phone: _____

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

Insured's name: _____ Relation: _____

Insured's birthdate: ____ / ____ / ____ Insured's ID #: _____

Insured's employer: _____

Employer's address: _____

■ SECONDARY

Orthodontic coverage? Yes No

Dental coverage? Yes No

Insurance company name: _____

Their address: _____

Their phone: _____

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

Insured's name: _____ Relation: _____

Insured's birthdate: ____ / ____ / ____ Insured's ID #: _____

Insured's employer: _____

Employer's address: _____

5. Emergency contact information

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

Name: _____ Relation: _____

Home phone: _____

Work phone (include ext.): _____

6. Medical history

Do you have a personal physician? Yes No

Physician's name: _____

Phone: _____ Date of last visit: _____

Over please!

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 using a prescribed method of birth control? Yes No _____

Are you pregnant? Yes No Week number: _____

Are you nursing? Yes No _____

7. Are there medical problems?

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

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial bones/joints/valves | <input type="checkbox"/> Y <input type="checkbox"/> N High/low blood pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for any reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital heart defect | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation therapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Drug/alcohol abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Severe/frequent headaches |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/seizures/fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell disease/traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever blisters/herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart attack | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers/colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart surgery/pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |

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

Are you allergic to any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Latex |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any metals/plastics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Other |
| <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | |

Please list any other drugs/materials to which you are allergic: _____

8. 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 physical health is: Good Fair Poor

Do you like your smile? Yes No 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 while awake? Yes No

Do you generally breathe through your mouth while asleep? Yes No

Do you have ever taken Fosomax or any other bisphosphonate? Yes No

Have you ever taken Phen-Fen? Yes No

Do you smoke or use tobacco in any form? Yes No

9. Understanding and authorization

I understand that the information 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. This office reserves the right to verify the credit status of potential 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. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of patient _____

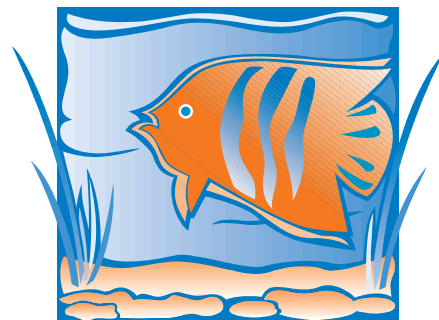
Date _____

If this office accepts insurance, I understand that I'm responsible for payment of services rendered and also responsible for any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature of patient _____

Date _____

Thank you!



TAN ORTHODONTICS

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