

PATIENT REGISTRATION

Date _____

PATIENT INFORMATION

Computer # _____ Office: _____

Last Name _____ *First Name* _____ *Middle Initial* _____

Address _____

City _____

State _____ Zip _____

Preferred Phone (_____) _____

Home Phone (_____) _____

Email _____

Dentist _____

Sex: M F Birthday _____ / _____ / _____

Whom may we thank for referring you? Please specify.

Dentist: _____

Google/Internet

Yelp

Friend: _____

Family: _____

Invisalign

Berkeley Parents Network

Other: (Please specify) _____

PRIMARY INSURANCE

Is patient covered by dental insurance? Yes No. If yes, please complete the following.

Is your insurance an ACA (Affordable Care Act) plan? Yes No.

Subscriber Last Name _____ *First Name* _____ *Middle Initial* _____

Relation to Patient _____ Birthday _____

Name of Employer _____

Insurance Company _____

Contact # _____ Group # _____

Subscriber Soc. Sec. # _____

Subscriber # _____

Delta/CA or Delta/State: _____

Employer Phone (_____) _____

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

ADDITIONAL INSURANCE

1. Name of Policy Holder: _____

2. Name of Policy Holder: _____

Birthday _____ Insurance Company _____

Birthday _____ Insurance Company _____

Contact # _____ Group # _____

Contact # _____ Group # _____

Subscriber Soc. Sec. # _____

Subscriber Soc. Sec. # _____

DENTAL HISTORY & STATUS

When were you last seen by a dentist? _____

Yes No Are you taking any pills or medications for dental reasons? If yes, please elaborate _____

Yes No Have there been any unusual reactions to dental medications? If yes, please elaborate _____

Yes No Have you had trouble associated with dental treatment? If yes, please elaborate _____

Yes No Have you seen a periodontist, endodontist, or oral surgeon? If yes, please elaborate _____

Yes No Have you had previous orthodontic treatment or consultation? If yes, when? _____

Yes No Has any member of your family had orthodontic treatment? If yes, please elaborate _____

Yes No Have you had any teeth extracted? If yes, why? _____

Yes No Have you ever injured or broken any teeth? If yes, please elaborate _____

Yes No Have you ever been injured in the head or face? If yes, please elaborate _____

Yes No Do you have any missing or extra teeth? If yes, please elaborate _____

Yes No Do you have any problem with eating, chewing, or swallowing? If yes, please elaborate _____

Yes No Do you have any dental or facial pain? If yes, please elaborate _____

Yes No Do your jaw joints make noise or hurt when opening, closing or chewing?

If yes, please elaborate _____

Yes No Do you habitually grind or clench teeth together?

Yes No Are you aware of any swellings or growths in the mouth or on your face?

If yes, please elaborate _____

Yes No Do you have any negative or resistant feelings about orthodontic treatment?

Yes No Are you especially concerned about orthodontic treatment?

Yes No Are you dissatisfied with the appearance of your teeth?

Yes No Are you specifically resistant to braces?

Yes No Are you specifically resistant to headgear?

Yes No Is there any other information we should know?

If yes, please elaborate _____

MEDICAL HISTORY

Who is your physician? _____ Phone: _____

When were you last seen by a physician? _____

Yes No Have you seen an *ENT specialist, endocrinologist, neurologist, allergist, hematologist, cardiologist, psychiatrist, or plastic surgeon*? If yes, please circle all that apply.

Yes No Is there a current medical problem? If yes, please elaborate _____

Yes No Are you taking any pills, medications, or drugs? If yes, please elaborate _____

Yes No Have you had an unusual reaction to any medication? If yes, please elaborate _____

Yes No Are you receiving or ever received Biphosphonate treatment (e.g., Fosamax)?

Yes No Do you have any know allergies? If yes, please elaborate? _____

Yes No Have you had a serious illness? If yes, please elaborate? _____

Yes No Have you had any surgery or been hospitalized? If yes, please elaborate _____

Yes No Are there any congenital (that the patient was born with) problems? If yes, please elaborate _____

Have you ever been diagnosed or treated for any of the following?

Yes No *Diabetes*

Yes No *Anemia*

Yes No *Liver problem*

Yes No *Thyroid problem*

Yes No *Jaundice*

Yes No *Tonsilitis*

Yes No *Sickle cell anemia*

Yes No *Cancer*

Yes No *Fainting*

Yes No *Heart trouble*

Yes No *Breathing trouble*

Yes No *Epilepsy*

Yes No *AIDS or HIV+*

Yes No *Rheumatic Fever*

Yes No *Tuberculosis*

Yes No *Emotional problems*

Yes No *Cerebral palsy*

Yes No *Kidney problem*

Yes No *Prolonged bleeding*

Yes No *Arthritis*

Yes No *Asthma*

Yes No *Bone disease*

Yes No *Hepatitis*

Yes No *Low blood pressure*

Yes No *Multiple sclerosis*

Yes No *Stomach ulcers*

Reason for visit:

Family member's who have had treatment at Berkeley/Orinda Orthodontics

Signature _____ Date _____

Print Name _____