Dula Orthodontics

A B C

Patient Information

Date: _____ Patient # _____

Patient's Name _____
Last First Middle

Home Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, parent's or guardian's name _____

If patient is a minor, parent's marital status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Does the person named above have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you to our office? _____

Is another member of your family a patient at this office? ❑ Yes ❑ No

Their Name _____

Patient's Dentist _____ Date of Last Visit _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Home Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Billing Address (if different from home address) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Verified on: **Insurance Information** **Effective Date:**

Insured's Name _____ Date of Birth _____

Relationship to patient _____ Employer _____

Subscriber#/ID# _____ Payor ID# _____

Social Security # _____ Group # _____ Ins. Tele# _____

Ins. Co. Name _____ Ins. Co. Address _____

Dual Coverage? Yes____ No____ _____

If Yes, Insured's Name _____

Relationship to Patient _____ Employer _____

Social Security # _____ Group ID# _____ Ins. Tele# _____

Ins Co. Name _____ Ins. Co. Address _____

Ortho Cov. Yes____ No____

Lifetime Max: _____

Used: _____

Payment % _____

Deductible: _____

Billing: Auto _____

Need to Bill? _____

Other Information: _____

_____

_____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Telephone _____

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HEALTH HISTORY

CIRCLE ONE

1. Do you have a personal physician? . . . . . YES NO
   Physician's Name _____ Date of last physical examination _____
   Address _____ Phone # _____
2. Your current physical health is ❑ Good ❑ Fair ❑ Poor
3. Have you been under the care of a Physician in the last two years? . . . . . YES NO
   If yes, please explain _____
4. Have you taken any prescription / over-the-counter medications or drugs during the past two years? . . . . . YES NO
   If yes, please list _____
5. Are you currently taking any prescription / over-the-counter medications or drugs of any kind? . . . . . YES NO
   If yes, please list _____
6. Do you now have, or have you ever had a substance abuse problem? . . . . . YES NO
7. Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance? . . . . . YES NO
   If yes, please list _____
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? . . . . . YES NO
9. Do your ankles swell during the day? . . . . . YES NO
10. Do you use more than 2 pillows to sleep? . . . . . YES NO
11. Have you lost or gained more than 10 pounds in the past year? . . . . . YES NO
12. Do you ever wake up from sleep short of breath? . . . . . YES NO
13. Have you ever had, or do you currently have any of the following diseases or medical problems?

Heart Attack	YES	NO	Endocrine or Thyroid Problems	YES	NO	Emphysema	YES	NO
Stroke	YES	NO	Kidney Problems	YES	NO	Allergies/Hay Fever	YES	NO
Heart Surgery	YES	NO	Shingles	YES	NO	Arthritis/Rheumatism	YES	NO
Heart Pacemaker	YES	NO	Cold Sores/Fever Blisters	YES	NO	Drug/Alcohol Addiction	YES	NO
Heart Murmur	YES	NO	Severe/Frequent Headaches	YES	NO	Problems with the Immune System	YES	NO
Rheumatic Fever	YES	NO	Epilepsy/Seizures	YES	NO	HIV+/Aids	YES	NO
Congenital Heart Defect	YES	NO	Fainting/Dizzy Spells	YES	NO	Hepatitis A (Infectious)	YES	NO
Mitral Valve Prolapse	YES	NO	Nervousness	YES	NO	Hepatitis B	YES	NO
Artificial Heart Valves	YES	NO	Psychiatric Treatment	YES	NO	Liver Disease	YES	NO
Artificial Joints (Hip, Knee, Etc.)	YES	NO	Diabetes	YES	NO	Yellow Jaundice	YES	NO
High/Low Blood Pressure	YES	NO	Polio, Mumps, Pneumonia	YES	NO	Venereal Disease (Syphilis, Gonorrhea, Condyloma)	YES	NO
Anemia	YES	NO	Tuberculosis	YES	NO	Ulcers/Colitis	YES	NO
Blood Transfusion	YES	NO	Difficulty Breathing	YES	NO	Glaucoma	YES	NO
Hemophilia/Abnormal Bleeding	YES	NO	Sinus Problems	YES	NO	Birth Defects or Hereditary Problems	YES	NO
Sickle Cell Disease	YES	NO	Adenoids Removed	YES	NO	Hospitalized For Any Reason	YES	NO
Bruise Easily	YES	NO	Tonsils Removed	YES	NO			
Cancer/Chemotherapy or X-Ray Treatment	YES	NO	Asthma	YES	NO			

14. Do you have any disease, condition, or problem not listed? . . . . . YES NO
    If yes, please explain _____
15. Have there been any injuries to the face, mouth, teeth, or chin? . . . . . YES NO
16. Do you now have, or have you ever experienced any jaw joint pain or discomfort? . . . . . YES NO
17. Are you aware of having any missing or extra permanent teeth? . . . . . YES NO
18. Have you ever had or been evaluated for orthodontic treatment before? . . . . . YES NO
19. Do you feel nervous about having orthodontic treatment, should it be indicated? . . . . . YES NO
20. What is your primary concern? (Why are you here?) _____

I have read and understand the above questions. I will not hold Dr. Dula or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform Dr. Dula's office.

The undersigned hereby authorizes Dr. Dula to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Dula to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Dula to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (*Name of Patient*)_____, and further authorize and consent that Dr. Dula choose and employ such assistance as deemed fit. I understand that this office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at it's discretion, use the services of one or more credit reporting agencies.

Patient_____ Date_____ Witness _____

Parent or Guardian_____ Relationship to Patient _____

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