ekim ORTHODONTICS

Patient Information

PATIENT'S NAME (Last, First, Middle Initial)		PREFERRED NAME	TODAY'S DATE / /
STREET ADDRESS			HOME PHONE ( )
CITY	STATE ZIP		CELL PHONE ( )
BIRTH DATE / /	AGE	☐ MALE ☐ FEMALE	EMAIL ADDRESS (to receive appointment reminders, check your account online, receive office updates)
MARITAL STATUS: S M WID SEP DIV OTHER			DRIVER'S LICENSE
OCCUPATION		EMPLOYER	DAY-TIME PHONE
SPOUSE'S NAME		SPOUSE'S OCCUPATION	DAY-TIME PHONE
How did you hear about Ekim Orthodontics?			
Any family members seen at Ekim Orthodontics? Name _____ Relationship _____			

Medical Health Information

Are you under the care of a physician? ☐ Yes ☐ No	Has there been any change in your general health within the past year? ☐ Yes ☐ No	Have you been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
NAME OF YOUR PHYSICIAN	PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE NUMBER ( )

Do you have or have you had any of the following:

- Scarlet Fever, Rheumatic Heart Disease ☐ Yes ☐ No
- Heart Defect, Heart Murmur, Heart Disease ☐ Yes ☐ No
  - Explain:_____
  - Are antibiotics required for dental visits? ☐ Yes ☐ No
- High or Low Blood Pressure ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- Headaches or Migraines ☐ Yes ☐ No
- Excessive Bleeding or Bruising ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Fainting Spells, Seizures ☐ Yes ☐ No
  - Date of last one: _____
- Diabetes ☐ Yes ☐ No
- Allergies (medicine or other) ☐ Yes ☐ No
  - Specify:_____
- Sinus Trouble ☐ Yes ☐ No
- Asthma, Hay Fever ☐ Yes ☐ No
- Joint Replacement or Implant ☐ Yes ☐ No
  - Are antibiotics required for dental visits? ☐ Yes ☐ No
- Treatment with bisphosphonate drugs ☐ Yes ☐ No
  - eg. Fosamax, Boniva, Actonel
- Currently Pregnant ☐ Yes ☐ No
- Drug or Alcohol Dependency ☐ Yes ☐ No
- AIDS, HIV positve ☐ Yes ☐ No
- Herpes, Fever Blisters ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No

If yes to any of the above, please explain:

Do you have any disease, condition, diagnosis or problem not listed? Please explain:

Are you taking any medication at this time? ❑ Yes ❑ No If yes, please list them and what they're taken for:

Dental Health Information

Are you experiencing any dental problems? ☐ Yes ☐ No	DATE OF DENTAL VISIT / /	How often does your child brush and floss each day? Brushes _____ times per day Flosses _____ times per day
FAMILY DENTIST	DENTIST'S LOCATION	DENTIST'S PHONE NUMBER ( )

Do you have or have you had any of the following diseases or problems?

- Tooth Sensitivity to Heat, Cold or Sweets ☐ Yes ☐ No
- Sore or Bleeding Gums ☐ Yes ☐ No
- Wisdom Tooth Extraction ☐ Yes ☐ No
- Diagnosis of TMJ or TMD ☐ Yes ☐ No
- Clicking, Popping or Locking of Jaw Joints ☐ Yes ☐ No
- Jaw Pain (Joint, Ear, Side of Face) ☐ Yes ☐ No
- Head, Neck or Jaw Injury ☐ Yes ☐ No
- Periodontal Disease ☐ Yes ☐ No
- Permanent Tooth Extractions ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No
- Diagnosis of TMJ or TMD ☐ Yes ☐ No
- Clenching or Grinding ☐ Yes ☐ No
- Adenoids or Tonsils Removed ☐ Yes ☐ No
- Smoking or Tobacco Use ☐ Yes ☐ No
- Fear of Dental Work ☐ Yes ☐ No
- Dental Trauma ☐ Yes ☐ No
  - Explain_____
- Previous Orthodontics ☐ Yes ☐ No
  - If yes, where & what?_____
- Any Upcoming Dental Treatment Planned ☐ Yes ☐ No
  - Explain_____

SIGNATURE ON FILE: By signing below:

I authorize the use of a copy of this form which can be used in place of the original. It is my responsibility to inform the office of any future changes. I attest that all the above and back of this form is true and accurate.

Signature _____ Date _____

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Dental Insurance Information

PRIMARY INSURANCE COMPANY NAME	COMPANY ADDRESS	GROUP / PLAN NUMBER
PRIMARY POLICY HOLDER'S NAME	SOCIAL SECURITY NUMBER / ID NUMBER	DATE OF BIRTH / /
SECONDARY INSURANCE COMPANY NAME	COMPANY ADDRESS	GROUP / PLAN NUMBER
SECONDARY POLICY HOLDER'S NAME	SOCIAL SECURITY NUMBER / ID NUMBER	DATE OF BIRTH / /

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Signature _____ Date _____

BELOW IS FOR FUTURE UPDATES

DATE: _____

STREET ADDRESS		EMAIL
CITY		HOME PHONE
STATE	ZIP	CELL PHONE

MEDICAL UPDATE:	**DENTAL UPDATE:**
Do you have any medical updates: ☐ Yes ☐ No If yes, please explain:	Dentist's Name: _____ Last Visit: _____ Any treatment planned: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	COMPANY ADDRESS	GROUP / PLAN NUMBER
PRIMARY POLICY HOLDER'S NAME	SOCIAL SECURITY NUMBER / ID NUMBER	DATE OF BIRTH / /
SECONDARY INSURANCE COMPANY NAME	COMPANY ADDRESS	GROUP / PLAN NUMBER
SECONDARY POLICY HOLDER'S NAME	SOCIAL SECURITY NUMBER / ID NUMBER	DATE OF BIRTH / /

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EMAIL FORM