BRUSH n BRACE (858) 800-2000
Happiness starts Here: Smile!
ALPINE ORTHODONTICS (619) 445-8883
Cynthia Jackson, DDS, MS
J. Shahangian, DDS, MS, INC

Patient's Name _____ Preferred Name _____

Sex: M ☐ F ☐ Birth Date: _____ Age ____ School _____ Grade _____

Residence Address _____ Email _____

Cell _____ Who can we thank for referring you to our practice? _____ _____

Marital status: birth parents or self (if adult): Married ☐ Divorced ☐ Separated ☐ Single/Widowed ☐

Patient's Physician _____ Address _____ Phone _____

Patient's Dentist _____ Address _____ Phone _____

FATHER'S INFORMATION (or self if adult)

Name _____ Employer _____ Occupation _____

Address _____ Cell _____ Date of Birth _____

MOTHER'S INFORMATION (or wife/husband if adult)

Name _____ Employer _____ Occupation _____

Address _____ Cell _____ Date of Birth _____

PERSON RESPONSIBLE FOR ACCOUNT

First & Last Name _____ Address _____

Home Phone _____ Work Phone _____ Cell _____

Email _____ (we do most of our communications via email and NEVER spam.)

Orthodontic Insurance? _____ Ins. Company _____ Social Security# _____

MEDICAL INFORMATION

Your estimation of patient's general health: Good ☐ Fair ☐ Poor ☐

Has there been any change in health in the last year? _____ What? _____

Does patient have any history of major illness? _____ What? _____

List medications being taken and reasons or write "None" _____

Is patient frequently ill? _____ If yes, reason: _____

List any allergies or write "None" _____

List drug sensitivities or write "None" _____

Tonsils removed? _____ Age: _____ Adenoids removed? _____ Age: _____

Boys: voice change? _____ Age: _____ **Girls:** started period? _____ Age: _____

+18 yrs Girls : pregnant? _____ Months into pregnancy: _____ Date due: _____

Check any of the following for which the patient has a history of:

YES	NO		YES	NO		YES	NO	
☐	☐	Diabetes	☐	☐	Herpes	☐	☐	Prosthetic valve/limb etc.
☐	☐	Epilepsy	☐	☐	Chicken pox	☐	☐	Kidney involvement
☐	☐	Liver disease	☐	☐	Heart trouble	☐	☐	Frequent headaches
☐	☐	Heart murmur	☐	☐	Scarlet fever	☐	☐	Hives or skin rash
☐	☐	High blood pressure	☐	☐	Tuberculosis	☐	☐	Fainting or dizziness
☐	☐	Aids	☐	☐	Bone disorders	☐	☐	Prolonged bleeding
☐	☐	Asthma	☐	☐	Developmental delay	☐	☐	Sinus trouble
☐	☐	Jaundice	☐	☐	Mental Illness	☐	☐	Endocrine problems
☐	☐	Arthritis	☐	☐	Rheumatic fever	☐	☐	Disability

Other: _____

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DENTAL HISTORY:

	YES	NO
Any history of injuries to face, mouth, or teeth?	☐	☐
Has patient ever sucked thumb, finger, lip, pen/pencil, etc.?	☐	☐
Until what age? _____		
Does patient have any speech problems?	☐	☐
Is nasal breathing difficult for patient?	☐	☐
Has patient been informed of any missing permanent teeth?	☐	☐
Has patient been informed of any extra permanent teeth?	☐	☐
Does patient have difficulty chewing food?	☐	☐
Does patient have bleeding gums?	☐	☐
Has patient ever had mouth or lip sores, which were slow to heal?	☐	☐
Is patient worried about orthodontic treatment?	☐	☐
Is patient dissatisfied with appearance of teeth or other facial structure?	☐	☐
Is patient extremely sensitive regarding statements concerning facial/teeth anatomy or appearance? _____	☐	☐
Has patient had previous orthodontic treatment or consult?	☐	☐
Has either parent had orthodontic treatment?	☐	☐
Were extractions necessary?	☐	☐
Is patient adopted?	☐	☐
Are you aware that not all appointments can be made after school/work hours?	☐	☐

When did you become aware of the orthodontic problem? _____

What are your primary concerns? _____

Last general dental cleaning date (mo./yr.): _____ Last general/dental exam date (mo./yr.): _____

Dental work pending? Write "None" or Describe: _____

PATIENT (adult) or PARENT's SIGNATURE _____ **DATE** _____

Doctor's notes:

_____

_____

_____

_____

_____

_____

_____

_____