

(858) 800-2000

ALPINE ORTHODONTICS



(619) 445-8883

CYNTHIA JACKSON, DDS, MS
J. SHAHANGIAN, DDS, MS, INC

Happiness starts Here: Smile!

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:

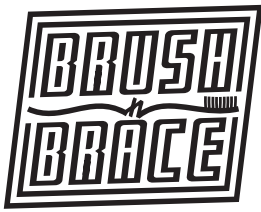
Boys: voice change? Age: Girls: started period? Age:

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

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

Table with 3 columns of YES/NO checkboxes for various medical conditions: Diabetes, Epilepsy, Liver disease, Heart murmur, High blood pressure, Aids, Asthma, Jaundice, Arthritis, Herpes, Chicken pox, Heart trouble, Scarlet fever, Tuberculosis, Bone disorders, Developmental delay, Mental Illness, Rheumatic fever, Prosthetic valve/limb etc., Kidney involvement, Frequent headaches, Hives or skin rash, Fainting or dizziness, Prolonged bleeding, Sinus trouble, Endocrine problems, Disability.

Other:



(858) 800-2000



(619) 445-8883

Happiness starts Here: Smile!

CYNTHIA JACKSON, DDS, MS
J. SHAHANGIAN, DDS, MS, INC

DENTAL HISTORY:

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