MINERA
ORTHODONTICS

We would like to welcome you to our office.
Please complete both of these forms. All information is confidential. Thank you.

PATIENT INFORMATION

Patient's Name:_____ Gender/Gender Identity: _____
Age: _____ Birth Date: _____ Social Security #: _____
Home Address: _____
Home Phone:_____ Cell/Work Phone: _____
E-Mail: _____
If patient is a minor, give parent or guardian's names: _____
Who may we thank for referring you to our office? _____

IF UNDER 18

School: _____ Grade:_____
Hobbies:_____ Siblings: _____
Has any family member had braces before? If so, who?_____

RESPONSIBLE PARTY

First name:_____ Last Name:_____ MI:_____ Marital Status:_____
Home Address: _____
Mailing Address: _____
Previous Address (if less than 3 years): _____
Home Phone:_____ Cell/Work Phone: _____
E-Mail: _____
Relation to patient:_____ Social Security #:_____
Employer: _____ Occupation:_____ No. Years employed: _____
Employer's address & phone number: _____
_____
Spouse's Name: _____ Occupation:_____ Relation to patient:_____

INSURANCE INFORMATION

Full Name of Insured:_____ Birth Date: _____
Social Security #:_____ Relation to Patient:_____
Mailing Address: _____
Home Phone:_____ Cell/Work Phone: _____
E-Mail: _____
Insurance Company: _____ Group Number: ID # _____
Insurance Co. Address and Phone number: _____

EMERGENCY

Name of nearest relative not living with you:_____
City _____ State: _____ Zip:_____

DENTAL/MEDICAL HISTORY

Dentist's Name: _____

Phone: _____ Date of last cleaning? _____

Physician's Name: _____

Phone: _____ Date of last visit? _____

Has an orthodontist previously been consulted? _____ If so, when? _____

What concerns would you like orthodontics to accomplish? _____

❑ Yes ❑ No Is the patient currently under a physician's care?
If yes, for what reason? _____

❑ Yes ❑ No Have the tonsils and adenoids been removed?

❑ Yes ❑ No Has the patient ever sucked a thumb or finger? Until what age? _____

❑ Yes ❑ No Is the patient currently taking any drugs/medications?
If yes please list: _____

❑ Yes ❑ No Does the patient have any allergies?
If yes please list: _____

❑ Yes ❑ No Has there ever been an adverse reaction to latex or nickel?

❑ Yes ❑ No Does the patient need antibiotics before seeing the dentist?

Please check any of the following conditions that the patient has had or now has

❑ Abnormal Bleeding	❑ Diabetes	❑ Jaw/Facial injuries	❑ Rheumatic Fever
❑ Anemia	❑ Epilepsy/Seizures	❑ Jaw Locking	❑ Ringing in the Ears
❑ Arthritis	❑ Fainting Spells	❑ Kidney Problems	❑ Sinus Trouble
❑ Asthma	❑ Frequent Headaches	❑ Liver Problems	❑ Smoke/Chew Tobacco
❑ Canker Sores	❑ Heart Murmur	❑ Mental Disorders	❑ Sore Facial Muscles
❑ Clenching/Grinding of Teeth	❑ Hepatitis	❑ Mouth Breathing	❑ Speech Problems
❑ Congenital Heart Lesions	❑ HIV/AIDS	❑ Persistent Cough	❑ Stomach Ulcers
❑ Dental/Tooth Injuries	❑ High/Low Blood Pressure	❑ Pregnant Now?	❑ Tuberculosis

❑ Yes ❑ No Do you have any medical or dental problems not listed above?
Please explain _____

AFFIRMATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status
I hereby give Dr. Minera and Team permission to perform an extensive oral exam, take low dosage digital radiographs and photos. I also give permission to confirm appointments using the phone number(s) I have provided, to include leaving messages.

Signature Patient/Parent/Guardian _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the Patient/Parent/Guardian.

Signed: _____ Date: _____