Columbus Orthodontic Center

CENTER FOR COSMETIC ORTHODONTIC TREATMENT

Amin Mason, DDS, MSD
New Patient Information (Adult)

Patient's Name:_____

Today's Date: _____/_____/_____

Patient Information

Date of Birth: ____/____/_____ Age: _____
Sex: ☐ Male ☐ Female
Address:_____
City: _____ state: _____ Zip:_____
E-mail:_____
Home Phone:_____
Cell Phone: _____
Employer: _____
Occupation: _____
Marital status: ☐ M ☐ S ☐ D ☐ W

Spouse's Information if married

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____
Employer: _____
Occupation: _____

Emergency Contact Information

In case of an emergency who should we contact?
Name: _____
Phone #: _____
Relationship to you: _____

Other Information

How did you hear about us? (Please circle your answer)

Dentist referral Insurance referral Internet search

Mailer Drive-by

Friends/Family (specify who):_____

Other: _____

What is the Primary reason that you are seeing an Orthodontist today? _____
Have you had any other consultation regarding your treatment? ☐ Yes ☐No
Are you transferring from another Orthodontist? ☐ Yes ☐ No
Previous Orthodontist's Name: _____
Were you satisfied with your previous Orthodontic treatment? ☐ Yes ☐ No If No, please explain: _____

_____

From scale of 1-10, how attractive do you rank your smile? (1= least attractive, 10= very attractive) _____

What type/types of treatment are you interested in?

☐Traditional Braces ☐Invisalign Clear Aligners
☐Clear Braces ☐ Lingual/ Hidden Braces

Insurance Information

Do you have Insurance? ☐ Yes ☐ No
Do you have more than one Insurance? ☐ Yes ☐ No

Primary Insurance Information

Members Name: _____
Member ID # (SS#): _____
Date of Birth: _____/_____/_____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Other
Other (Please Explain): _____
Insurance Carrier: _____
Insurance Phone #:_____
Insurance address: _____
City: _____ State: _____ Zip: _____
Group, Plan or Policy #: _____
Employer: _____

Secondary Insurance must be filed by the patient

Patient Dental History

Dentist Name: _____
Address: _____
Phone: _____
Date of Last Visit for cleaning: Month (_____)/Year(_____)
Were there any cavities or dental problems present?
☐ Yes ☐No If yes, please explain: _____

Have you ever had gum (Periodontal) disease? □ Yes □ No

How often do you brush your teeth? __times □ daily

How often do you floss?□ Never □ Sometimes □ Often

Do you smoke or chew tobacco? □ Yes □No

Have you ever experienced any dental or facial trauma? (Examples include: Dental injuries, car accident, jaw or facial injuries related to sports or falling). □Yes □No
If yes, Please Explain:_____

Do you experience or have experienced the following?
___Grinding/clenching ___Jaw popping
___Jaw/Joint clicking ___Ringing in ears
___Jaw/Joint soreness ___Excessive headaches
___Muscular soreness around head/neck

Have you ever been advised to take antibiotics before dental appointments? □ Yes □ No
Please explain: _____

Patient Medical History

Do you snore or have you been told that you snore at night? □ Yes □ No
Do you have difficulty in breathing when you sleep at night? □ Yes □ No
Are you tired in the mornings when you wake up? □ Yes □ No

Do you have a hyperactive gag reflex? □ Yes □ No

For Female Patients only
Are you pregnant/possibly pregnant or nursing? □ Yes □ No

Do you have or have you ever had a history of the following? *Please circle "Y" for yes or "N" for no.*

Heart murmur	Y	N	Hepatitis	Y	N
Blood disease	Y	N	Herpes	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N
Heart disease	Y	N	Tuberculosis	Y	N
HIV/AIDS	Y	N	High Blood pressure	Y	N
Diabetes	Y	N	Endocrine problem	Y	N
Tonsillitis	Y	N	Prolonged bleeding	Y	N
Jaundice	Y	N	Bone disorder	Y	N
Asthma	Y	N	Rheumatoid arthritis	Y	N
Mouth breathing	Y	N	Sinus Infections	Y	N
Allergic reaction	Y	N	Surgeries	Y	N
Sleep Apnea	Y	N	Radiation	Y	N
Chemotherapy	Y	N	Cancer	Y	N
Anxiety	Y	N	Osteoporosis	Y	N
Depression	Y	N	Mental disorders	Y	N

List ALL current or previous illnesses or medical conditions not listed above: _____
_____
_____

Are you currently taking any medications? □Yes □No
Please list and specify the reason:
_____
_____
_____

Do you have any allergies to latex, food or **any** medications? □ Yes □No Please list: _____
_____

Are you currently under the care of a physician? □ Yes □No
Name of Physician: _____
Phone: (___)____-_____ Address: _____
City: _____ State: _____ Zip: _____

X

Patient /Responsible party's Signature: DATE:

Doctors Comments: _____

Doctor's Signature: _____ Date:_____/_____/_____