



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 for your visit today?

Have you had a consultation previously? Yes No

Are you transferring from another practice? 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 orthodontic benefits under a DENTAL insurance?

Yes NO

Subscriber's Name _____

Subscriber's relationship to patient: Mother Father

Spouse Other: _____

Subscriber's Date of Birth: ____/____/____

Subscriber's member ID # (Some insurances require SS#):

Group, Plan or Policy #: _____

Name of subscriber's employer: _____

Insurance company's name: _____

Insurance company's Phone #: _____

Insurance address: _____

City: _____ State _____ Zip _____

ALL insurance information must be completed to verify benefits. Please provide us with a copy of your dental insurance card.

Secondary Insurance must be filed by the patient.

Patient Dental History

Dentist's 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 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 accidents, jaw or facial injuries related to sports or falling). Yes No

If yes, Please Explain:

Do you experience or have ever 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

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: _____

YOUR NAME:

SIGNATURE:

Doctor's Comments:

Doctor's Signature: _____

Date: _____/_____/_____