



**PATIENT INFORMATION FOR ADULTS
(INFORMACIÓN DEL PACIENTE PARA ADULTOS)**

Date (Fecha): _____

Patient's name (Nombre del paciente): _____

Street Address (Dirección): _____

City/County (Ciudad/País): _____ State (Estado): _____ Zip (Código postal): _____

Phone (Teléfono): _____ Phone type (Type de teléfono): _____

Other phone (Otro teléfono): _____ Phone type (Type de teléfono): _____

Email: _____ Gender (Sexo): Male Female

Birthdate (Fecha de Nacimiento): _____ Social Security # (No. de Seguro Social): _____

Employer (Empleado(a) por): _____ Occupation (Ocupación): _____

Name of person to contact in case of an emergency (En caso de emergencia, ¿a quién se deberá notificar?):

Phone (Teléfono): _____

DENTAL INSURANCE INFORMATION (INFORMACION DEL SEGURO DENTAL)

Primary Insured's Name (Nombre del asegurado): _____

Insured's Social Security # (No. de Seguro Social): _____

Insured's birthday (Nacimiento del asegurado): _____

Insurance Company (Nombre de la compañía del Seguro Dental): _____

Group No. (Número del grupo): _____ Member ID No. (No. De Poliza): _____

Insurance phone number (Teléfono del Seguro) _____

DENTAL HISTORY (Historia Dental)

Name of your dentist (Nombre de su dentista): _____

Phone # (Teléfono): _____

Approximately how long ago was your last visit to the dentist? (Fecha de la última visita al dentista?)

What is the reason for seeking a consultation from an orthodontist? (¿Cuál es la razón para buscar una consulta con un ortodoncista?)

How did you hear about our office? (¿Cómo se enteró de nuestra oficina?)

YES NO

- _____ _____ Is the patient presently in any dental pain? If so, where: _____
(¿Está el paciente actualmente en dolor dental? Si la respuesta es afirmativa, ¿dónde?)
- _____ _____ Has the patient ever had braces, expanders, retainers, or Invisalign before?
(¿El paciente ha tenido frenos, expansores, retenedores o Invisalign antes?)
- _____ _____ Has the patient ever had an orthodontic consultation before?
(¿El paciente alguna vez ha tenido una consulta de ortodoncia?)
- _____ _____ Have there been any injuries to face, mouth, or teeth?
(¿Ha habido alguna lesión a la cara, la boca o los dientes?)
- _____ _____ Has the patient ever been diagnosed with gum disease?
(¿El paciente ha sido diagnosticado con la enfermedad de las encías?)
- _____ _____ Has the patient ever had history of jaws locking up, jaw pain, or limited jaw movements?
(¿Alguna vez ha tenido el paciente dolor en la mandíbula o movimientos mandibulares limitados?)

MEDICAL HISTORY (Historia Medico)

YES NO

- _____ _____ Is the patient taking any medication? _____
(¿Está tomando Ud. actualmente algún medicamento?)
- _____ _____ Is the patient allergic to metal, latex, or any medication?
(¿Tiene Ud. alguna alergia a metal, látex, o algún medicamento?)
- If so please list (¿Cuáles?): _____
- _____ _____ Any medical conditions? _____
(¿Alguna condición médica?)
- _____ _____ Has the patient had any operations? _____
(¿Ha tenido alguna cirugía?)
- _____ _____ Ever been involved in a serious accident? _____
(¿Alguna vez ha sido involucrado en un accidente grave?)

Mark any of the medical conditions below that the patient has had or currently has.
(Por favor marque Sí o No)

- | YES | NO | | YES | NO | |
|------------|-----------|---|------------|-----------|--|
| _____ | _____ | Heart Problems (Problemas del Corazón) | _____ | _____ | ADHD (TDAH/trastornos sensoriales) |
| _____ | _____ | Diabetes | _____ | _____ | Epilepsy (Epilepsia) |
| _____ | _____ | Asthma or Hay fever (Enfermedades Respiratorias) | _____ | _____ | Abnormal bleeding /Hemophilia
(Enfermedad de la Sangre/Hemofilia) |
| _____ | _____ | HIV / Aids (VIH/SIDA u Otros Trastornos Inmunosupresores) | _____ | _____ | Bone Disorders |

Is the patient pregnant? (¿Sospecha Ud. que está embarazada?): _____ (Yes/ Sí) _____ (No)

Are there any medical conditions we have not discussed that you feel we should be aware of? (¿Hay alguna otra cosa que nosotros debiéramos saber sobre su historia clínica?)

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Jones to perform a complete orthodontic evaluation. (He contestado sinceramente a todas las preguntas y estoy de acuerdo de informar a esta oficina de cualquier cambio en mi historial médico o dental. Asimismo, autorizo a la Dra. Jones para realizar una evaluación de ortodoncia completa.)

Signature (Firma): _____ Date (Fecha): _____

PATIENT RECORD OF DISCLOSURES (REGISTRO DE DIVULGACION DEL PACIENTE)

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (Deseo que me contacten de la siguiente manera)

- Home Telephone: _____
- Work Telephone: _____
- Cell Number: _____
- Written Communication (Email or Post Mail): _____

PLEASE LIST ANY PERSON(S) WHOM YOU ARE AUTHORIZING US TO DISCLOSE INFORMATION REGARDING YOUR ORTHODONTIC TREATMENT: (POR FAVOR MENCIONE CUALQUIER PERSONA A LA QUE USTED NOS AUTORIZA A DIVULGAR INFORMACION SOBRE SU TRATAMIENTO DE ORTODONCIA)

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

PLEASE LIST ANY PERSON(S) WHOM YOU ARE NOT AUTHORIZING US TO DISCLOSE INFORMATION REGARDING YOUR ORTHODONTIC TREATMENT: (POR FAVOR MENCIONE CUALQUIER PERSONA A LA QUE NO NOS AUTORIZA A DIVULGAR INFORMACION SOBRE SU TRATAMIENTO DE ORTODONCIA)

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ RELATIONSHIP: _____



Appointment Policy for **NEW PATIENT**

Thank you for choosing our office for your orthodontic care. We value the time you invest for your appointments. As you may be aware, orthodontic treatments can take several months to years to complete. In order to ensure that you are seen in a timely manner and that your treatment progresses accordingly, we ask all of our patients to honor our appointment policy. We appreciate your compliance and we look forward to serving your orthodontic needs.

- **Patients who arrive late may not be seen and will result in a no-show.**
- Please allow at least **ONE BUSINESS DAY** prior notice to reschedule or cancel the appointment(s) in order to avoid a \$50 no-show fee.
- A no-show is defined as:
 - Complete no-show on the day of the appointment
 - Cancellation on the day of the appointment
 - Rescheduling on the day of the appointment
 - Arriving late which will result in rescheduling appointment for another day

After-School Appointments

We strive to accommodate children in school with afternoon appointments. However, certain procedures will need to be scheduled in the morning. Please expect some missed days of school throughout the course of treatment.

Many of our patients are children who are currently attending school. According to the American Association of Orthodontics (AAO), children undergoing orthodontic treatment may miss 3 to 4 school days per year. AAO research has demonstrated that children who miss school due to orthodontic treatment do NOT suffer academically. Instead, the research indicates that children who receive orthodontic care often do better in school compared to their peers.

Signature: _____

Date: _____