



**PATIENT INFORMATION FOR MINORS (below age 18)**  
(INFORMACION DEL PACIENTE PARA MENORES (menores de 18 años))

Date (Fecha): \_\_\_\_\_

Patient's name (Nombre del paciente): \_\_\_\_\_

Nickname (Apodo): \_\_\_\_\_

Gender (Sexo): \_\_\_\_\_ Male \_\_\_\_\_ Female

Birthdate (Fecha de Nacimiento): \_\_\_\_\_

School (Escuela): \_\_\_\_\_

Sports/Hobbies (Deporte/Pasatiempos): \_\_\_\_\_

**PARENT INFORMATION (Informacion del responsable) Please give primary on insurance if applicable.**

Name (Nombre): \_\_\_\_\_

Relationship to Patient (Relación al paciente): \_\_\_\_\_ (Mom)(Madre) \_\_\_\_\_ (Dad)(Padre) \_\_\_\_\_ (Guardian/Other)(otro): \_\_\_\_\_

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: \_\_\_\_\_ Social Security # (No. de Seguro Social): \_\_\_\_\_

Birthdate (Fecha de Nacimiento): \_\_\_\_\_ Occupation (Ocupación): \_\_\_\_\_

Name of other parent/guardian (Nombre de otro pariente/guardián): \_\_\_\_\_

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 the patient's 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?)

\_\_\_\_\_ Has the patient ever had a history of sleep apnea?  
(¿Ha tenido el paciente apnea del sueño?)

**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?)

Circle 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

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?)

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Female Patients only: (Para pacientes femeninas)

Has menstruation started? (Empezo la menstruación): \_\_\_ (Yes/ Sí) \_\_\_ (No)

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

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): \_\_\_\_\_



### 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: \_\_\_\_\_