PERSONALIZED ORTHODONTICS
Alborzi
Alexa Alborzi, DDS, MDS, Inc.

Welcome to our Office

Please verify the information we have on file, make any necessary changes and *COMPLETE* all missing information.

PATIENT INFORMATION

Patient Name:		Patient ID #:	
Common Name:		Gender:	
Date of Birth:		Address:	
Home Phone:		Work Phone:	
E-Mail Address:		Cell Phone:	
Dentist:		Physician:	

Whom May We Thank for Referring You?

_____

Hobbies / Interests: _____

Have Any of Your Family Members Been a Patient Here? [ ] No [ ] Yes

If Yes, Please List Name(s) and Relation: _____

ACCOUNT INFORMATION

(Responsible Parties / Individual(s) Financially Responsible for Account)

		Person (2) Responsible for Account
Name & Relation to Patient:		
Address:		
City / State / Zip:		
How Long at Current Address:		
Phone Number(s):	Hm: Cell:	Hm: Cell:
E-Mail Address:		
Date of Birth:		
Employer:		
Employer's Phone Number:		
Length of Employment:		
Occupation / Title:		
Dental Insurance Company Name:		
Dental Insurance Company Phone:		
Group Identification #:		
Social Security #:		

***By signing below, I understand that the above "Account Information" can be used for Credit Inquiry purposes in order to extend credit options for my orthodontic care. (Inquiries of this type do not affect your credit rating.)**

***Responsible Party's Signature: _____ Date: _____**

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EMERGENCY INFORMATION

Name of nearest relative *not* living with you: _____ Relationship to Patient _____

Complete Address: _____

Home Phone: _____ Alternate Phone: _____

Video Recording/Surveillance

I understand that Dr. Alborzi may conduct video surveillance of the premises at any time (the only exception being the restroom) and video cameras will be positioned in appropriate areas for training purposes and for the security of our facilities.

CONFIDENTIAL CHANNELS OF COMMUNICATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to request that communications concerning your personal health information be made through confidential channels (telephone, mail and email).

In addition to contact information provided by me on Page 1, the following channels of communication may be used:

FAX: _____

OTHER: _____

I hereby request the use of the confidential channels of communication provided by me on Page 1 of this form for the communication of information related to the personal health, treatment or payment for treatment.

Responsible Party's Signature: _____ Date: _____

PHOTO AND VIDEO RELEASE

I give permission for Dr. Alexa Alborzi and Alborzi Orthodontics to use my photos and/or videos for the purpose of publication, promotion, illustration or advertising such as on our website, www.GotToSmile.com, Facebook, Instagram, YouTube, etc. I understand that only the photo or video and first names only will be published.

Responsible Party's Signature: _____ Date: _____

[ ] Place an X here if you do not give permission for use of photos and/or videos. Your signature above is still required.

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MEDICAL / DENTAL HISTORY

PATIENT INFORMATION

1. What is your main concerns regarding your jaws and teeth?

__ Crowding	__ Openbite	__ Gummy Smile	__ Dizziness
__ Spacing	__ Protrusion	__ Gum Disease	__ Difficulty Opening
__ Overbite	__ Receded Jaw	__ Receding Gums	__ Difficulty Closing
__ Underbite	__ Prominent Jaw	__ Missing Teeth	__ Ringing in Ears
__ Crossbite	__ Irregular/Mis-shaped teeth	__ TMJ Problems	__ Other _____

2. Other family members with similar orthodontic conditions?

__ Father __ Mother __ Sister __ Brother __ Other _____

MEDICAL/DENTAL HISTORY

		Good		*Fair*		*Poor*
1. Present Health:	a) Physical:	1	2	3	4	5
	b) Emotional:	1	2	3	4	5

2. Have you ever had any of the following conditions? __ **NO**

__ Aids	__ Allergies	__ Asthma
__ Arteriosclerosis	__ Autoimmune Disorder	__ Dizziness
__ Blood Disease	__ High Blood Pressure	__ Hepatitis
__ Bone Disorders	__ Low Blood Pressure	__ Heart Murmur
__ Disturbed Sleep	__ Epilepsy	__ Cancer
__ Endocrine Problems	__ Emotional Problems	__ Diabetes
__ Female Problems	__ Heart Disease	__ Rheumatic Fever
__ Hearing Disorder	__ Kidney Disease	__ Ringing in the Ears
__ Trauma to Face / Teeth / Head / Jaws		

3. Have you ever been exposed to any of the following aerosol transmissible diseases by <u>Droplet</u> in the <u>last 6 months</u>? __ **NO**

__ SARS	__ Pneumonia	__ Parvovirus B19
__ Meningitis	__ Diphtheria	__ Pertussis or Whooping Cough
__ Pharyngitis	__ Rubella	__Mycoplasmal Pneumonia
__ Mumps	__Haemophilus Flu Type B	__ Group A Streptococcus (GAS)
__ Viral Hemorrhagic Fevers (VHFs)		

4. Have you ever been exposed to any of the following aerosol transmissible diseases by <u>Airborne</u> solids in the <u>last 6 months</u>? __ **NO**

__ Avian Flu	__ Anthrax	__ Smallpox	__ Seasonal Flu
__ Novel H1N1 Flu	__ Any Novel Flu	__ Shingles	__ Chicken Pox
__ Measleas	__ Tuberculosis		

5. Past and Current medications taken:
   __ Heart Pills (Digitalis, etc.) __ Muscle Relaxants _____
   __ Sleeping Pills __ Diet Pills (Diuretics, Fen-Phen, Redux, etc.)
   __ Insulin __ Antibiotics _____
   __ Birth Control Pills __ Vitamins _____
   __ Biphosphonates (Intraveneous or Oral) such as Fosomax, Didronel, Aredia, Zometa, Actonel, Acetenol, Boniva, Reclast, Skelid or Bonefos or any other bone medications (Taken for such things ad Bone Diseases, Bone Cancer, Osteoporosis or Osteopenia)
   __ Other Medications:_____ __ **NONE**

6. Are you allergic to any medications or foods? *YES* *NO*
   If *yes*, please specify _____

7. Do you:
   __ Snore when sleeping? Or __ Have Sleep Apnea
   __ Have difficulty swallowing? __ Have difficulty chewing? __ Have Tongue thrust?
   __ Have frequent colds, sore throats, or ear aches? __ Have speech problems?
   __ Have clicking in the jaw joint? __ Have pain in the jaw joint?
   __ Grind his/her teeth? _ __ Smoke?
   __ Suck his/her thumb *or* fingers? *NEVER* *PREVIOUSLY (Up to what age? ___)* *PRESENTLY*

8. Do you mostly breathe through the: *MOUTH* *NOSE* *BOTH*

9. Females Only: Are you currently pregnant? *YES* *NO*

ATTITUDE TOWARD TEETH & TREATMENT:

1. How often do you get dental check-ups? *Twice/Year* *Once/Year* *Only if Urgent* *Never*

   Date of your last dental check-up: _____

2. Are you aware of any orthodontic problem? *YES* *NO*

3. What is your interest in orthodontic treatment:
   __ Wants Treatment __ Treatment if Necessary
   __ Unwilling but Agrees __ Un-cooperative

4. Your orthodontic consultation was prompted by:
   __ Myself __ Dentist __ Family Members
   __ Spouse __ Physician __ Friend __ Other _____

5. Previous orthodontic consultation? *YES* *NO* Previous orthodontic treatment? *YES* *NO*

6. Are there any unusual dental, medical, or surgical problems not covered above that Dr. Alborzi should be aware of?_____

7. Why are you seeking this consultation?
   __ To correct overbite __ To eliminate crowding
   __ To correct jaw dysfunction problem __ To close spaces
   __ To improve facial proportions __ To eliminate facial pain
   __ To improve general appearance __ Other _____

8. How do you feel about your smile? What are you most excited about changing in your smile?
   _____

9. How do you feel about wearing braces? _____

Signing below indicates that the Medical/Dental History provided is true and accurate to the best of my knowledge.

Responsible Party's Signature: _____ Date: _____