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:		Cell Phone:	
Dentist:		Physician:	

Whom May We Thank for Referring You?

_____

Hobbies / Interests: _____

School: _____ Grade: _____

Name(s) & Birthdate(s) of Sibling(s): _____ Is Child Adopted? [ ] No [ ] Yes

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

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

ACCOUNT INFORMATION

(Individual(s) Responsible for Account)

PARENTS MARITAL STATUS: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Remarried

	Person (1) Responsible for Account	Person (2) Responsible for Account
Name:		
Relationship 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 child's orthodontic care. (Inquiries of this type do not affect your credit rating.)**

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

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 of my child.

Responsible Party's Signature: _____ Date: _____

EMERGENCY INFORMATION

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

Complete Address: _____

Home Phone: _____ Alternate Phone: _____

ADDITIONAL INSURANCE INFORMATION (IF APPLICABLE)

If there is **additional** insuranc, please complete the information below.

[ ] *There is no other insurance for my child's account.*

	Other Person (1) Responsible for Account
Name:	
Relationship:	
Address:	
City / State / Zip:	
Phone Number(s):	Hm: Cell:
Date of Birth:	
E-Mail Address:	
Employer:	
Employer's Phone Number:	
Dental Insurance Company Name:	
Dental Insurance Company Phone:	
Group Identification #:	
Social Security #:	

PHOTO AND VIDEO RELEASE

I give permission for Dr. Alexa Alborzi and Alborzi Orthodontics to use photos and/or videos of my child 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.

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

MEDICAL / DENTAL HISTORY

PATIENT INFORMATION

1. What is the patient's or parents' main concerns regarding the 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. Has your child reached puberty? *YES* *NO*

3. Has your child 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		

4. Has your child 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)		

5. Has your child 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		

6. Past and Current medications taken by your child:
   __ Heart Pills (Digitalis, etc.) __ Muscle Relaxants _____
   __ Sleeping Pills __ Diet Pills (Diuretics, Fen-Phen, Redux, etc.)
   __ Insulin __ Antibiotics _____
   __ Birth Control Pills __ Vitamins _____
   __ Biphosphonates (Intravenous 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 Cancers, Osteoporosis or Osteopenia)
   __ Other _____ __ **NONE**

7. Is your child allergic to any medications or foods? *YES* *NO*
   If *yes*, please specify _____

8. Does your child:
   __ 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? *PRESENTLY* *NEVER* *PREVIOUSLY (Up to what age? ___)*

9. Does your child mostly breathe through the: *MOUTH* *NOSE* *BOTH*

ATTITUDE TOWARD TEETH & TREATMENT:

1. How often does your child get dental check-ups? *Twice/Year* *Once/Year* *Only if Urgent* *Never*
   Date of last dental check-up? _____
2. Aware of orthodontic problem? *YES* *NO*
3. Patient's interest in orthodontic treatment:
   __ Wants Treatment __ Treatment if Necessary
   __ Unwilling but Agrees __ Un-cooperative
4. Orthodontic consultation prompted by:
   __ Patient __ Dentist __ Mother __ Father __ Other _____
   __ Spouse __ Sibling __ Physician __ Friend
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 improve general appearance
   __ To eliminate facial pain __ To improve facial proportions __ To close spaces
   __ To correct jaw dysfunction problem __ Other _____

Please ask your child the following questions:

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

PERSONALIZED ORTHODONTICS

Alborzi

Alexa Alborzi, DDS, MDS, Inc.

Pediatric Sleep Questionnaire

Patient Name: _____ Date: _____

Dr. Alborzi would like you to complete this form as accurately and honestly as possible. In our practice, we are very interested in our patients' overall health. Orthodontic treatment can be an important part of managing the health problems caused by sleep and breathing disorders.

____ While Sleeping, does your child snore more than half the time?
____ While Sleeping, does your child always snore?
____ While Sleeping, does your child snore loudly?
____ While Sleeping, does your child have "heavy" or loud breathing?
____ While Sleeping, does your child have trouble breathing, or struggle to breath?
____ Have you ever seen your child stop breathing during the night?
____ Does your child occasionally wet the bed, sleepwalk, or have night terrors (circle any)?
____ Does your child tend to breathe through the mouth during the day?
____ Does your child have a dry mouth on waking up in the morning?
____ Does your child wake up unrefreshed in the morning?
____ Does your child wake up with headaches in the morning?
____ Is it hard to wake your child up in the morning?
____ Does your child have a problem with sleepiness during the day?
____ Has a teacher or supervisor commented -your child appears sleepy during the day?
____ Did your child stop growing at a normal rate at any time since birth?
____ Is your child overweight?
____ This child often does not seem to listen when spoken to directly
____ This child often has difficulty organizing task and activities
____ This child often is easily distracted by extraneous stimuli
____ This child often fidgets with hands or feet or squirms in seat
____ This child often is 'on the go' or often acts as if 'driven by a motor'
____ This child often interrupts or intrudes on others (butts into conversations or games)

Total Score = _____

Orthodontics is MUCH more than straight teeth!

Ronald D. Chervin, et al *Arch Otolaryngol Head Neck Surg.* 2007;133(3):216-222