

Welcome! Our specialty is creating smiles and to do this, we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.

Care Orthodontics
 88 Tully Road, Ste 113
 San Jose, CA 95111
 (408) 971-2885, Fax (408)971-2831
www.CareOrthodontics.com

Date _____ Updated _____

Patient Information

Patient Legal Name _____ Name you would like to be called _____ Male / Female
 Address _____ Apt.# _____ City _____ State _____ Zip _____
 Home Phone _____ Patient E-Mail _____ Birthdate _____
 Dentist _____ Social Security # _____

Reason for seeking treatment? _____

Mark all the ways you have heard about our office: Dentist Referral Dental Office Staff Location Reputation
 Internet Search Care Ortho Website Invisalign Commercial Invisalign Website Insurance Listing I am a former patient
 Newspaper Phone Book Coupon in Mail Transferring Orthodontist _____
 I know a Care Orthodontic patient _____ NAME _____
 Care Orthodontics Employee _____ NAME _____ Family member had treatment here _____ NAME _____

*** REQUIRED * Responsible Party Information**

Name _____ E-Mail _____
 Address _____ City _____ State _____ Zip _____
 Marital Status _____ Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security # _____ Birthdate _____ Relationship to Patient _____
 Employer _____ Occupation _____
 Spouse's Name _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security # _____ Birthdate _____ Relationship to Patient _____
 Employer _____ Occupation _____

Orthodontic Insurance Information

Primary _____ Soc. Sec. # _____ Birthdate _____
 Employer _____ Member ID# _____
 Insurance Company _____ Phone # _____
 Insurance Company Address _____ Group # _____
 Secondary
 Insured _____ Soc. Sec. # _____ Birthdate _____
 Employer _____ Member ID# _____
 Insurance Company _____ Phone # _____
 Insurance Company Address _____ Group # _____

Authorization Information

▶ I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ I hereby authorize payment directed to Nancy Phan, D.D.S., M.S. of the insurance benefits otherwise payable to me.

 Signed (Patient, or Parent of Minor) Date

 Signed (Insured Person) Date

Emergency Information

In case of emergency, please contact _____ Phone _____

Relationship to patient _____

Medical History

Is the patient in good health? Yes / No Is the patient under the care of a physician? Yes / No Physician's Name _____

If so, explain _____

Presently taking any medication? _____

If so, explain _____

Does the patient have any history of: (please check yes or no) _____

- | | | | | |
|---|---|---|--|---|
| Y N | Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Aids |
| <input type="checkbox"/> <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Kidney or liver disease | <input type="checkbox"/> <input type="checkbox"/> T.B. | <input type="checkbox"/> <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Brain injury | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Trouble Hearing |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> <input type="checkbox"/> Metal Allergy | <input type="checkbox"/> <input type="checkbox"/> or any other medical condition we should be aware of | |
| <input type="checkbox"/> <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> <input type="checkbox"/> any adverse reactions to anesthesia | | | |

Dental History

Dentist _____ Date of last visit _____

Y N

Does patient have any oral habits? (Thumb sucking / lip biting / mouth breathing) _____

Does patient have pain in the jaw joints? Right _____ Left _____

Does patient have popping or cracking of the jaw joints? Right _____ Left _____

When did this begin? _____

Does the patient have headaches of any kind? Sinus _____ Forehead _____ Temple _____

How often? _____ Ear pain _____ Neck / Shoulder pain _____

Has any other family member had orthodontic treatment? _____

Is there anything else that you feel we should know regarding this patient? _____

Benefits of Orthodontics

Your protected health information (PHI) may be used in connection with your treatment, payment of your account or health care operations. Our office will not disclose PHI except as otherwise required for treatment, diagnosis, and billing, the individual's rights, and the practice's obligations.

Orthodontics is a service that provides an improvement in the appearance of the teeth and function of the teeth, and in general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I state that I have read and understand the above, and have truthfully to the best of my ability answered all of the questions on this form.

Patient / Parent _____ Date _____

Thank you so much for taking your valuable time to fill out this form. The better we know you, the more we can be of service to you.