Patient # ____________

Appointment Date/Time: ____________

RONALD D. Mizrahi

DDS, PC | practice limited to orthodontics

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.

PATIENT INFORMATION

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Patient's Name ____________ (First) ____________ (Last) ____________ (Nickname) ☐ Male ☐ Female

Address ____________ (Street) ____________ (Apt. #) ____________ (City) ____________ (State) ____________ (Zip)

Home Phone ____________ Birthdate ____________ Age ______ Social Security # ____________

School ____________ Grade ____________ Email ____________

Hobbies/Interests ____________

If patient is a minor, give parent's or guardian's name ____________

Do you have legal custody of this child? ☐ Yes ☐ No

List brothers/sisters & age(s) ____________

How did you hear about our office? ____________

Friends or family treated by Dr. Mizrahi ____________

RESPONSIBLE PARTY INFORMATION

Name ____________ (First) ____________ (Last) ____________ (Marital Status)

Mailing Address ____________ (Street) ____________ (City) ____________ (State) ____________ (Zip)

How long at this address ______ Home Phone ____________ Cell Phone ____________ Work Phone ____________

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________ Email ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Spouse's Name ____________ (Last) ____________ (First) ____________ (Middle) Relationship to Patient ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Social Security # ____________ Birthdate ____________ Work Phone ____________

INSURANCE INFORMATION

Orthodontic Coverage ☐ Yes ☐ No ☐ Don't know

Primary Insurer:

If YES, Insured's Name ____________

Social Security # ____________ Birthdate ____________

Insurance Company ____________ Group No. ____________ Plan ____________

Insurance Co. Address ____________ Insurance Co. Phone # ____________

Do you have dual coverage ☐ Yes ☐ No

Secondary Insurer:

If YES, Insured's Name ____________

Social Security # ____________ Birthdate ____________

Insurance Company ____________ Group No. ____________ Plan ____________

Insurance Co. Address ____________ Insurance Co. Phone # ____________

EMERGENCY INFORMATION

Name of nearest friend/relative not living with you ____________

Address ____________ (Street) ____________ (City) ____________ (State) ____________ (Zip)

Home Phone ____________ Work Phone ____________ Ext: ____________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY

Physician ______________________ Date of last visit ______________

Current physical health? ☐ Good ☐ Fair ☐ Poor

Circle YES or NO: **If YES:**

YES NO Are you taking any medications? List: ______________

YES NO Are you allergic to any medications? List: ______________

YES NO Have you had any serious injury to head or neck? Describe: ______________

YES NO Have tonsils or adenoids been removed? When: ______________

YES NO If patient is a minor, has puberty begun? Age: ______________

Check any medical conditions you have had or are currently being treated for:

☐ AIDS/HIV+	☐ Blood Disorders	☐ Endocrine Problems	☐ Hemophilia	☐ Rheumatic Fever
☐ Anemia	☐ Bone Disorders	☐ Epilepsy/Convulsions	☐ Hepatitis	☐ Sinus Problems
☐ Arthritis	☐ Diabetes	☐ Handicaps/Disabilities	☐ Herpes	☐ Thyroid
☐ Asthma or Hay Fever	☐ Dizziness/Fainting	☐ Heart Defects	☐ High Blood Pressure	☐ Tuberculosis
☐ Allergy to Latex/Metal	☐ Emotional Problems	☐ Heart Murmur	☐ Migraines	☐ Tumor or Cancer

List any other medical condition or problem: ______________

Do you need to be premedicated prior to dental procedures ☐ YES ☐ No If so, state medication and reason ______________

____

DENTAL HISTORY

Dentist ______________________ Date of last visit ______________

Circle YES or NO (if YES, please fill in details): ______________

YES NO Have there been any injuries to the face, mouth, teeth or chin? ______________

YES NO Do you have any missing or extra permanent teeth? ______________

YES NO Do your gums routinely bleed when you brush? ______________

YES NO Do you have any speech problems? ______________

YES NO Do you have a thumb, finger or tongue thrust problem? ______________

YES NO Do you breathe through your mouth, or are your lips often parted? ______________

YES NO Have you ever had any orthodontic treatment? When? ______________

YES NO Has anyone in the family received orthodontic treatment? Who? ______________ When? ______

YES NO Do you have any pain or soreness around your eyes, neck or back? If so:

Which side? ☐ Left ☐ Right ☐ Both How frequent? ☐ Constant ☐ Periodic

YES NO Do you feel you clench or grind your teeth during the day or at night? ______________

YES NO Are you aware of your jaw joints clicking, popping or locking? If so: ______________

Which side? ☐ Left ☐ Right ☐ Both How frequent? ☐ Constant ☐ Periodic

YES NO Are you aware that orthodontic appointments will infringe on some school or work time?

What would you like orthodontics to accomplish? ______________

____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

I understand the information I have given is correct to the best of my knowledge, and it will be held in the strictest of confidence by this office. It is my responsibility to inform the dental staff of any changes in the medical status. I authorize the doctor to perform any necessary dental services with my informed consent that may be needed during diagnosis and treatment. I also understand that this office reserves the right to verify the credit status of potential patients and /or parents of patients prior to extending credit for treatment fees. I acknowledge receipt of this office's notice of Privacy Practices.

X ______________________ X ______________

Signature of Patient/Parent or Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein. Initials: Doctor ______ TC ______ Date ______