Polaris Orthodontic Center

CENTER FOR ADULT AND ADOLESCENT ORTHODONTIC TREATMENT

Amin Mason, DDS, MSD

New Patient Information (Adult)

Patient's Name: _____

Today's Date: _____/_____/_____

Patient Information

Date of Birth: ____/____/_____ Age: _____

Sex: ☐ Male ☐ Female

Address:_____

City: _____ state: _____ Zip:_____

E-mail:_____

Home Phone:_____

Cell Phone: _____

Employer: _____

Occupation: _____

Marital status: ☐ M ☐ S ☐ D ☐ W

Spouse's Information if married

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Employer: _____

Occupation: _____

Emergency Contact Information

In case of an emergency who should we contact?

Name: _____

Phone #: _____

Relationship to you: _____

Other Information

How did you hear about us? (Please circle your answer)

Dentist referral Insurance referral Internet search

Mailer Drive-by

Friends/Family (specify who):_____

Other: _____

What is the primary reason for your visit today?

_____

Have you had a consultation previously? ☐ Yes ☐ No

Are you transferring from another practice? ☐ Yes ☐ No

Previous Orthodontist's name: _____

Were you satisfied with your previous Orthodontic treatment? ☐ Yes ☐ No If No, please explain: _____

_____

From scale of 1-10, how attractive do you rank your smile? (1= least attractive, 10= very attractive) _____

What type/types of treatment are you interested in?

☐ Traditional Braces **☐ Invisalign Clear Aligners**

☐ Clear Braces **☐ Lingual/ Hidden Braces**

Insurance Information

Do you have orthodontic benefits under a DENTAL insurance?

☐ Yes ☐ NO

Subscriber's Name_____

Subscriber's relationship to patient: ☐ Mother ☐ Father

☐ Spouse ☐ Other: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's member ID # (Some insurances require SS#):

_____

Group, Plan or Policy #: _____

Name of subscriber's employer: _____

Insurance company's name: _____

Insurance company's Phone #: _____

Insurance address: _____

City: _____State _____Zip_____

ALL insurance information must be completed to verify benefits. Please provide us with a copy of your dental insurance card.

Secondary Insurance must be filed by the patient.

Patient Dental History

Dentist's Name: _____

Address: _____

Phone: _____

Date of Last Visit for cleaning: Month (_____)/Year (_____)

Were there any cavities or dental problems present?

□ Yes □No If yes, please explain: _____

Have you ever had gum (Periodontal) disease? □ Yes □ No

How often do you floss?□ Never □ Sometimes □ Often

Do you smoke or chew tobacco? □ Yes □ No

Have you ever experienced any dental or facial trauma? (Examples include: Dental injuries, car accidents, jaw or facial injuries related to sports or falling). □Yes □ No

If yes, Please Explain:

_____

Do you experience or have ever experienced the following?

___Grinding/clenching ___Jaw popping

___Jaw/Joint clicking ___Ringing in ears

___Jaw/Joint soreness ___Excessive headaches

___Muscular soreness around head/neck

Have you ever been advised to take antibiotics before dental appointments? □ Yes □ No

Please explain: _____

Patient Medical History

Do you snore or have you been told that you snore at night?

□ Yes □ No

Do you have difficulty in breathing when you sleep at night?

□ Yes □ No

Are you tired in the mornings when you wake up? □ Yes □ No

For Female Patients only

Are you pregnant/possibly pregnant or nursing? □ Yes □ No

Do you have or have you ever had a history of the following? ***Please circle "Y" for yes or "N" for no.***

Heart murmur	Y	N	Hepatitis	Y	N
Blood disease	Y	N	Herpes	Y	N
Anemia	Y	N	Epilepsy/Seizures	Y	N
Heart disease	Y	N	Tuberculosis	Y	N
HIV/AIDS	Y	N	High Blood pressure	Y	N
Diabetes	Y	N	Endocrine problem	Y	N
Tonsillitis	Y	N	Prolonged bleeding	Y	N
Jaundice	Y	N	Bone disorder	Y	N
Asthma	Y	N	Rheumatoid arthritis	Y	N
Mouth breathing	Y	N	Sinus Infections	Y	N
Allergic reaction	Y	N	Surgeries	Y	N
Sleep Apnea	Y	N	Radiation	Y	N
Chemotherapy	Y	N	Cancer	Y	N
Anxiety	Y	N	Osteoporosis	Y	N
Depression	Y	N	Mental disorders	Y	N

List ALL current or previous illnesses or medical conditions not listed above: _____

_____

Are you currently taking any medications? □Yes □No

Please list and specify the reason:

_____

_____

_____

Do you have any allergies to latex, food or **any** medications?

□ Yes □ No Please list: _____

_____

Are you currently under the care of a physician? □ Yes □No

Name of Physician: _____

Phone: (___)____-_____ Address: _____

City: _____ State: _____ Zip: _____

YOUR NAME:

_____

SIGNATURE:

_____

Doctor's Comments:

Doctor's Signature: _____ Date:_____/_____/_____