



Polaris Orthodontic Center

CENTER FOR ADULT AND ADOLESCENT ORTHODONTIC TREATMENT

Amin Mason, DDS, MSD

New Patient Information (Adult)

Patient's Name: _____

Other: _____

Today's Date: ____/____/____

What is the Primary reason that you are seeing an Orthodontist today? _____

Have you had any other consultation regarding your treatment? Yes No

Are you transferring from another Orthodontist? Yes No
Previous Orthodontist's Name: _____

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

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

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

Spouse's Information if married

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Employer: _____

Occupation: _____

Insurance Information

Do you have Insurance? Yes No

Do you have more than one Insurance? Yes No

Primary Insurance Information

Members Name: _____

Member ID # (SS#): _____

Date of Birth: ____/____/____

Relationship to Patient: Self Spouse Other

Other (Please Explain): _____

Insurance Carrier: _____

Insurance Phone #: _____

Insurance address: _____

City: _____ State: _____ Zip: _____

Group, Plan or Policy #: _____

Employer: _____

Emergency Contact Information

In case of an emergency who should we contact?

Name: _____

Phone #: _____

Relationship to you: _____

Secondary Insurance must be filed by the patient

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): _____

Patient Dental History

Dentist 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 brush your teeth? ___times daily

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 accident, jaw or facial injuries related to sports or falling). Yes No

If yes, Please Explain: _____

Do you experience or have 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

Do you have a hyperactive gag reflex? 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: _____

X

Patient /Responsible party's Signature: _____

DATE: _____

Doctors Comments: _____

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