250 Montclair Ave., Suite A
San Jose, CA 95116
(408) 258-7141

1930 S. Bascom Ave., Suite 110
Campbell, CA 95008
(408) 377-3388

Kai Orthodontics

www.KaiOrtho.com

Please fill out this form completely, it is important for your orthodontic care.

Patient Information

Today's Date: _____

Name: _____ ☐ M ☐ F
Last First MI

Birthdate: ____/____/____ Age: _____ SS# : _____

Home Address: _____

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____)_____ Cell #: (_____)_____

Wk #: (_____)_____ DL #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

What time is best to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Dentist Name: _____

Previous or Present (Please Circle) Date of last visit? _____

Insurance Information

PRIMARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

SECONDARY

Orthodontic Coverage? ☐ Y ☐ N Dental Coverage? ☐ Y ☐ N

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate ____/____/____ Financial Institution _____

Employer _____ Work Phone _____ S.S.#/SIN _____

Continued on Back

Medical History

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Ph #: (_____) _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Y ☐ N

Have you had any metal rods, pins or implants? ☐ Y ☐ N

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

Please list each one: _____

Have you ever taken Phen-Fen(Redux or Pondimin)? ☐ Y ☐ N

If so, when? _____

WOMEN: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week #: _____

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding/Hemophilia	Y	N	Herpes/Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alcohol / Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized for Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease/Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

List any other drugs/material allergies: _____

_____ _____

Dental History

What would you like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you still have wisdom teeth? ☐ Y ☐ N

Have you ever had an injury to your: ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? ☐ Y ☐ N

Do you breathe through your mouth? ☐ While Awake ☐ While Asleep

Do you have any missing or extra permanent teeth? ☐ Y ☐ N

Do you like your smile? ☐ Y ☐ N

If not, what would you change? _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. 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 and may, at the discretion of the office, use the services of one or more credit reporting services.

_____

SIGNATURE DATE

If this office accepts insurance, I understand that I am responsible for payment of services rendered and for paying any co-payment that my insurance does not cover, including the deductible. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

SIGNATURE DATE

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

Office Use Only

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

Doctor's Comments: _____

_____

_____

_____