BAKAR'S Classic Smiles ORTHODONTICS

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name_____ Soc. Sec. #_____
Last Name First Name Middle (initial)

Address_____ Cell Phone_____

City_____ State_____ Zip_____ Email_____

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Whom may we thank for referring you?_____

Notify in case of emergency_____ Relation to the Patient_____

Home Phone_____ Cell Phone_____ Work Phone_____

Primary Dental Insurance

Person Responsible for Account_____
Last Name First Name Middle (initial)

Relation to Patient_____ Birth date_____ Soc. Sec. #_____

Address (if different from patient) _____ Home Phone_____

City_____ State _____ Zip_____

Cell Phone_____ Email_____

Person Responsible Employed by_____ Occupation_____

Insurance Company_____ Phone_____

Subscriber ID#_____ Group #_____

Name(s) of other dependents under this plan_____

Additional Dental Insurance

Is patient covered by an additional insurance? ☐ Yes ☐ No

Subscriber's Name_____
Last Name First Name Middle (initial)

Relation to Patient_____ Soc. Sec. #_____

Address (if different from patient)_____ Birth date_____

City_____ State _____ Zip_____ Home Phone_____

Cell Phone_____ Business Phone_____

Person Responsible Employed by_____ Occupation_____

Subscriber ID#_____ Group #_____

Name(s) of other dependents under this plan_____

Please complete both sides

Dental History

What would you like us to do today?_____

Are you in dental discomfort today?_____

General Dentist_____ Phone_____

Address_____ Dentist Email _____

Date of last dental care_____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

☐ Y ☐ N Sores or growths in mouth	☐ Y ☐ N Sensitivity to sweets	☐ Y ☐ N Sensitivity to cold	☐ Y ☐ N Sensitivity to hot
☐ Y ☐ N Food Collection between teeth	☐ Y ☐ N Bleeding gums	☐ Y ☐ N Sensitivity when biting	☐ Y ☐ N Periodontal treatment
☐ Y ☐ N Grinding or clenching teeth	☐ Y ☐ N Clicking or popping jaw	☐ Y ☐ N Loose teeth or broken fillings	☐ Y ☐ N Bad Breath

How often do you brush? _____ How often do you floss?_____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Medical History

Physician's Name_____ Address_____ Phone_____

Date of last visit_____ Have you ever had any serious illnesses or operations? ☐ Y ☐ N If yes, describe_____

Are you currently under physician care? ☐ Y ☐ N If yes, describe_____

Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate date(s)_____

Have you ever had Fen-Phen/ Redux? ☐ Y ☐ N Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control? ☐ Y ☐ N

Check Y for yes or N for no if you have or have not had the following:

☐ Y ☐ N AIDS/HIV Positive	☐ Y ☐ N Cough, persistent	☐ Y ☐ N High blood pressure	☐ Y ☐ N Shingles
☐ Y ☐ N Anaphylaxis	☐ Y ☐ N Cough up blood	☐ Y ☐ N Jaw pain	☐ Y ☐ N Shortness of breath
☐ Y ☐ N Anemia	☐ Y ☐ N Diabetes	☐ Y ☐ N Kidney disease or malfunction	☐ Y ☐ N Skin rash
☐ Y ☐ N Arthritis, Rheumatism	☐ Y ☐ N Epilepsy	☐ Y ☐ N Liver disease	☐ Y ☐ N Spina Bifida
☐ Y ☐ N Artificial heart valves	☐ Y ☐ N Fainting	☐ Y ☐ N Material allergies	☐ Y ☐ N Stroke
☐ Y ☐ N Artificial joints	☐ Y ☐ N Food allergies	(latex, wool, metal, chemicals)	☐ Y ☐ N Surgical implant
☐ Y ☐ N Asthma	☐ Y ☐ N Glaucoma	☐ Y ☐ N Mitral valve prolapse	☐ Y ☐ N Swelling of feet or ankles
☐ Y ☐ N Atopic (allergy prone)	☐ Y ☐ N Headaches	☐ Y ☐ N Nervous problems	☐ Y ☐ N Thyroid disease or malfunction
☐ Y ☐ N Back problems	☐ Y ☐ N Heart murmur	☐ Y ☐ N Pacemaker/heart surgery	☐ Y ☐ N Tobacco habit
☐ Y ☐ N Blood disease	☐ Y ☐ N Heart problems	☐ Y ☐ N Psychiatric care	☐ Y ☐ N Tonsillitis
☐ Y ☐ N Cancer	Describe_____	☐ Y ☐ N Rapid weight gain or loss	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Chemical dependency	☐ Y ☐ N Hemophilia/	☐ Y ☐ N Radiation treatment	☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Chemotherapy	Abnormal bleeding	☐ Y ☐ N Respiratory disease	☐ Y ☐ N Venereal disease
☐ Y ☐ N Circulatory problems	☐ Y ☐ N Herpes	☐ Y ☐ N Rheumatic fever	
☐ Y ☐ N Cortisone treatments	☐ Y ☐ N Hepatitis	☐ Y ☐ N Scarlet fever	

List medications you are currently taking:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.