ADVANCED ORTHODONTIC CENTER
Sam Veshkini D.M.D.

Thank You for choosing our office for you Orthodontic needs.

Whom may we thank for referring you to our office?

_____

Patient Information

Date: _____ Patient's Name: _____
Last First Middle

Address: _____ **E-Mail**: _____
Street City State Zip

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Social Security #: ___ - ___ - ___ Driver's License # _____ **Sex**: ___ Birthdate: ___ / ___ / ___

Emergency Contact: _____ Phone: (____) _____

Responsible Party Information

Name: _____ Marital Status: _____
Last First Middle

Mailing Address: _____ **E-Mail:** _____
Street City State Zip

How long at this address: _____ Home Phone: (____) _____ Work: (____) _____

Previous Address (if less than 3 years): _____
Street City State Zip

Social Security #: ___ - ___ - ___ Birthdate: ___ / ___ / ___ Relationship to patient: _____

Employer: _____ Occupation: _____ #of Years Employed: _____

Employer's Address: _____

Spouse's Name: _____ Relationship to Patient _____

Spouse's Employer: _____ Occupation: _____ #of Years Employed: _____

Employer's Address: _____

Spouse's Social Security #: ___ - ___ - ___ Birthdate: ___ / ___ / ___ Work Phone: (____) _____

Insurance Information

Subscriber's Name: _____ DOB: _____ Subscriber's Social Security #: ___ - ___ - ___

Insurance Company: _____ Group #: _____
Insurance Company Address: _____ Phone #: (____) _____
Do you have dual coverage? Yes __ No ___ *If yes:* please complete the following secondary Insurance Information.
Subscriber's Name: _____ DOB: _____ Subscriber's Social Security #: ___ - ___ - ___
Insurance Company: _____ Group #: _____
Insurance Company Address: _____ Phone #: (____) _____
Subscriber's Employer: _____ Phone #: (____) _____

26902 Oso Parkway, Suite #100 Mission Viejo Ca 92691 Tel (949) 855-2060 Fax (949) 582-1837

Dental Information

What is the date of your last dental examination? _____ What was done at the time? _____

Dentist's Name _____ City: _____ Phone: _____

Do your gums bleed when you brush? Never _____ Sometimes _____ Often _____ Always _____

Do you grind or clench your teeth? Yes ____ No ____

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

If I could change my smile I would make my teeth…( ) Whiter ( ) Straighter ( ) Close Spaces ( ) Repair Chips

WHY ARE YOU HERE TODAY? _____

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name: _____ Phone # (____) _____

Address: _____

4. Please list any medication or drugs taken during the past two years: _____
5. Are you now taking any medication or drugs? ..... YES NO

   If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? ..... YES NO
7. Indicate which of the following you have had or have at present (circle "yes" or "no" to each item):

Heart Murmur	YES	NO	Stroke	YES	NO	Ulcers	YES	NO
Mitral Valve Prolapse.....	YES	NO	Cancer	YES	NO	Cold Sores/Fever Blisters	YES	NO
Rheumatic Fever.....	YES	NO	Chemotherapy	YES	NO	Allergy to Latex	YES	NO
High Blood Pressure.....	YES	NO	Radiation Therapy ...	YES	NO	Tumors	YES	NO
Heart Disease or attack	YES	NO	Diabetes	YES	NO	Liver Disease	YES	NO
Angina Pectoris	YES	NO	Asthma	YES	NO	Hepatitis A (infections)	YES	NO
Artificial Joints (Hip, knee, etc.) ...	YES	NO	Hay Fever	YES	NO	Hepatitis B (Serum).....	YES	NO
Artificial Heart Valve	YES	NO	Allergies or Hives	YES	NO	Venereal Disease	YES	NO
Heart Pacemaker	YES	NO	Sinus Trouble	YES	NO	A.I.D.S.	YES	NO
Heart Surgery	YES	NO	Chronic Cough	YES	NO	H.I.V. Positive	YES	NO
Heart Failure	YES	NO	Emphysema	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Tuberculosis	YES	NO	Bleeding Problems	YES	NO
Congenital Heart Disease	YES	NO	Fainting or Dizzy Spells	YES	NO	Anemia	YES	NO
Arthritis	YES	NO	Epilepsy or Seizures ...	YES	NO	Sickle Cell Disease	YES	NO
Rheumatism	YES	NO	Thyroid Problems	YES	NO	Bruise Easily	YES	NO
Cortisone Medication	YES	NO	Glaucoma	YES	NO	Developmentally Disabled	YES	NO
Drug Addiction	YES	NO	Kidney Trouble	YES	NO	Nervousness	YES	NO

8. Are you on a special diet? ..... YES NO
9. Do you have, or have you had, any disease, condition, or problem not listed? ..... YES NO

FOR WOMEN ONLY: Are you pregnant? Yes ____ What Month? _____ No ____ Are you nursing? Yes___ No ____

Are you taking birth control pills? Yes ___ NO ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor, and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself, or my dependents, is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I acknowledge that I have reviewed a copy of the Dental Materials Fact Sheet and HIPPA Notice of Privacy Practices.
5. I understand that, where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Parent's Signature _____ Date _____ Witness _____

26902 Oso Parkway, Suite #100 Mission Viejo Ca 92691 Tel (949) 855-2060 Fax (949) 582-1837