BURLINGAME ORTHODONTICS, PLLC

CONFIDENTIAL

PATIENT INFORMATION FOR ADULT PATIENTS

Patient's name ______________________________ Date __________
Last First Middle

Title ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other __________ I prefer to be called __________

Home Address ______________________________
Street City Zip

Home phone __________ Work phone __________

Cell/other phone __________ Email address __________

Birthdate__________ Social Security #__________ Sex: ☐M ☐F

Occupation __________ Employer __________

Whom may we thank for referring you to our office? __________

Have any other family members been treated in our office? Please name them. __________

MEDICAL HISTORY

Primary Care Physician __________ Date of Last Visit__________
City, State__________ Phone __________

Other physician being seen now __________ Date of Last Visit__________
City, State__________ Phone __________
Reason __________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you currently taking any medication? __________
Yes No Are you allergic to any medication? __________
Yes No Are you allergic to anything else? (*latex, metals, foods*) __________
Yes No History of a major illness? __________
Yes No Have you had any operations? __________
Yes No Ever been involved in a serious accident? __________
Yes No Have you seen a physician in the last 12 months? __________
Yes No Have you ever taken bisphosphonates? Oral or IV? __________
Female Patients only:
Yes No Is there any chance you could be pregnant? __________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Dizziness/Fainting	Hepatitis/Liver problems	Neurological Disorders
Anemia	Endocrine or thyroid problems	Herpes	Pneumonia
Arthritis/Joint Problems	Epilepsy	High Blood Pressure	Prolonged Bleeding
Asthma or Hayfever	Gastrointestinal Disorders	History of Eating Disorder	Radiation/Chemotherapy
Birth Defects	Head/Neck/Face Injuries	HIV / Aids	Rheumatic Fever
Bone Disorders/Osteoporosis	Heart Murmur	Immune system problems	Tuberculosis
Diabetes	Heart problems	Kidney problems	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? __________
____

EMERGENCY CONTACT INFORMATION

Name of spouse or closest relative ____________________

Title ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other __________ Relationship to patient ____________________

Complete address (if different from above) ____________________
Street City Zip

Home phone ______________ Work phone ______________ Cell/other phone ______________

DENTAL HISTORY

General Dentist ____________________ Date of last visit ______________
City, State ____________________ Phone ______________

Other dentist/dental specialist ____________________ Date of Last Visit ______________
City, State ____________________ Phone ______________
Reason ____________________

What concerns you most about your teeth? ____________________
Any previous orthodontic treatment or consultations? ____________________

Yes	No	Are you presently experiencing any dental pain? ______________
Yes	No	Have you ever experienced any unfavorable reaction to dentistry? ______________
Yes	No	Have you ever chipped any teeth? ______________
Yes	No	Have your wisdom teeth been removed? ______________
Yes	No	Do you have a history of speech problems or speech therapy? ______________
Yes	No	Have there been any injuries to face, mouth, or teeth? ______________
Yes	No	Is any part of your mouth sensitive to temperature or pressure? Where? ______________
Yes	No	Do your gums bleed when brushing? ______________
Yes	No	Any type of habit? (chewing pens etc) ______________
Yes	No	Do you have trouble breathing through your nose? ______________
Yes	No	Do teeth or jaws ever feel uncomfortable first thing in the morning? ______________
Yes	No	Experience jaw clicking or popping? ______________
Yes	No	Aware of clenching or grinding teeth during the day? ______________
Yes	No	Experience “tension” headaches? ______________
Yes	No	Have you ever been treated for TMD problems? ______________
Yes	No	Do you wear a splint or nightguard? ______________
Yes	No	Do you smoke or chew tobacco? ______________
Yes	No	Do you have a history of smoking or chewing tobacco? ______________

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my medical and/or dental professionals and my medical and/or dental insurance company.

Signature: ____________________ Date: ______________

I have read the above questions and understand them. I have truthfully answered the above questions and agree to inform this office of any changes in my medical or dental history. I will not hold my orthodontist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Signature: ____________________ Date: ______________

I authorize Dr. Burlingame to perform a complete orthodontic evaluation including any necessary photos and radiographs.

Signature: ____________________ Date: ______________

BURLINGAME
ORTHODONTICS, PLLC

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Date___________________

Patient's name ____
Last First Middle

Birthdate__________________

DENTAL INSURANCE INFORMATION

Primary Coverage:

Policy Holder's Full Name_________________________ Birthdate ___________ Relationship to patient __________________

Insured's Social Security # ________________________ Insured's Employer ____

Insurance Company_________________________ Group # _________________ ID # ________________________________

Insurance Co. Address____ Phone No.________________________________

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

If Additional Coverage:

Policy Holder's Full Name_________________________ Birthdate ___________ Relationship to patient __________________

Insured's Social Security # ________________________ Insured's Employer ____

Insurance Company_________________________ Group # _________________ ID # ________________________________

Insurance Co. Address____ Phone No.________________________________

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

If Additional Coverage:

Policy Holder's Full Name_________________________ Birthdate ___________ Relationship to patient __________________

Insured's Social Security # ________________________ Insured's Employer ____

Insurance Company_________________________ Group # _________________ ID # ________________________________

Insurance Co. Address____ Phone No.________________________________

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know