Yamashiro ORTHODONTICS

INVISALIGN 2015 PREMIER PROVIDER

INVISALIGN 2016 PREMIER PROVIDER

INVISALIGN 2017 PREMIER PROVIDER

Patient Information

Name (First, M, Last) _____DOB _____Gender M / F

Address _____

City _____State_____Zip_____

Cell Phone# _____ (Self) Cell Phone#_____ (Emergency Contact)

Email _____OK to send emails? Yes / No

Dentist's name_____ Date of last visit_____

How did you hear about us? Google __Yelp__ Friend_____Dr._____

Whom may we thank for referring you to our practice?_____

List the names of any friends/family currently in the practice_____

List any sports, hobbies, or musical instruments played:_____

Insurance Information

Insurance Co._____ Phone #_____

Address _____

City _____State_____Zip_____

Subscriber's name (First, M, Last) _____DOB_____

Subscriber SSN# _____Patients SSN# _____

Subscriber ID#_____Group#_____

Employer_____

Office Use Only

Lifetime Max _____ % paid_____ Payout Mthly/Quarterly/Yearly Initial payout_____

Dental and Medical History

Has the patient had an orthodontic consult or treatment	Yes/No	If so, when?	

What is the main orthodontic concern? _____

_____

_____

List of Medications: _____

Do you have a latex allergy? _____

Speech Problems/Therapy	Yes/No	Grind or clench teeth?	Yes/No
Injury to face, jaw, teeth, or mouth?	Yes/No	Discomfort from teeth or gums?	Yes/No
Pain, tenderness, or noise in either jaw?	Yes/No	Frequent headaches?	Yes/No
Oral Habits (thumb/finger sucking or lip/nail biting?	Yes/No	Neck/shoulder pain?	Yes/No
Frequent sore throats?	Yes/No	Brush teeth daily?	Yes/No
Floss teeth daily?	Yes/No	Fluoride treatments?	Yes/No
Mouth breathing?	Yes/No	Snores during sleep?	Yes/No
Requires premedication?	Yes/No	Any missing or extra permanent teeth?	Yes/No
Apprehensive about dental care?	Yes/No	Frequently chew gum?	Yes/No

Rheumatic Fever	Yes/No	Tuberculosis/Lung disease	Yes/No
Pneumonia	Yes/No	Liver disease	Yes/No
Kidney disease	Yes/No	Heart Attack/Stroke	Yes/No
Heart disease	Yes/No	Congenital Heart Defect	Yes/No
Heart Murmur	Yes/No	Hemophilia	Yes/No
Hypertension/High blood pressure	Yes/No	Prolonged Bleeding/Transfusion	Yes/No
Anemia	Yes/No	HIV/AIDS	Yes/No
Hepatitis	Yes/No	Tonsils/Adenoids removed	Yes/No
Cancer	Yes/No	Family history of Cancer	Yes/No
Received radiation treatment	Yes/No	Growth Problems	Yes/No
Endocrine problems	Yes/No	Hormone Therapy	Yes/No
Metal allergy	Yes/No	Nervous disorders	Yes/No
Bone disorders/Bone loss	Yes/No	Diabetes	Yes/No
Seizures/Epilepsy	Yes/No	Handicaps/Disabilities	Yes/No
Treated for emotional problems	Yes/No	Arthritis	Yes/No

Signature: _____ Date: _____