Welcome to Sublime Smiles

The Orthodontic Offices of Dr. Avila

Patient Information

Name _____ Gender: M/F Today's Date _____
Birthday _____ Cell phone# _____ Email address_____
Home Address_____ City _____State_____ Zip _____
Other family members seen by us?_____
Name of Dentist_____ Phone # _____ City _____ Last visit_____
Who may we thank for referring you to us? _____

Parent/Guardian/Responsible Financial Party Information

Name of Mother:_____Cell#_____Email_____
Address:_____City_____State_____Zip_____
Name of Father:_____Cell#_____Email_____
Address:_____City_____State_____Zip_____
Please circle: Married/Separated/Divorced - If separated or divorced, would you like our office to create two separate financial accounts for your child's treatment? **Yes/No**

Dental Insurance Information

Dental Insurance Co. Name _____ Insurance ID # _____Group# _____
Insur Co address _____City _____State_____ Zip _____
Subscriber's Name_____ Subscriber's Birthday _____

Emergency Information

Name of person to contact in case of an emergency_____Relationship_____
Phone#_____

Patient Medical and Dental History

Y	N	Heart Murmur	Y	N	Bleeding problems of any kind
Y	N	Premedication before dental visits	Y	N	Hemophilia
Y	N	Heart disease	Y	N	Diabetes
Y	N	Heart Attack/Stroke	Y	N	Hepatitis
Y	N	Rheumatic fever	Y	N	HIV+/AIDS
Y	N	Asthma	Y	N	Speech problems
Y	N	Convulsions/Epilepsy	Y	N	Apprehensive about dental care
Y	N	Fibromyalgia	Y	N	Any missing or extra permanent teeth
Y	N	Any stays in hospital	Y	N	Grind or Clench teeth
Y	N	Currently taking any medications	Y	N	Jaw joint (TMJ) pain, clicking or popping
Y	N	History of Cancer and Cancer treatment	Y	N	Injuries to face, head or jaw
Y	N	Allergies (Nickel, Latex, Penicillin, Sulfa, Other)	Y	N	Oral habits (Nail-biting, thumb or lip-sucking, chewing ice or pens).
Y	N	Bone Disorders/Bone Loss			

If yes to any of above, please explain: _____
_____
Please list any medications you are currently taking: _____
_____
Do you have arthritis in any joints? Y / N Have you taken any type of osteoporosis medicine? Y / N
Has there ever been a time when your jaws did not open or close? Y / N
Do you have a history of periodontitis? Y / N Do you smoke? Y / N How often _____
Do you have any problem chewing, talking or swallowing? Y / N
How often do you have headaches? _____ How often do you take pain medication? _____
Have you previously had orthodontic treatment? Y / N -If yes, when did you finish treatment? _____
What concerns do you or your doctor have about your smile or teeth? _____
_____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Avila; Sublime Smiles to perform a complete orthodontic evaluation.

Signature: _____Date:_____