Welcome to Tavarez Orthodontics!

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

1. ABOUT YOU Today's Date: _____

E-Mail Address: _____

First Name: _____

Last Name: _____

I prefer to be called: _____ ❒ Male ❒ Female

Birth date: _____ Age: _____

Home Address: _____

_____

Do you Own or Rent? (circle one) How Long? _____

Cell #: **(_____)** _____

Wk #: (_____) _____ Ext: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

2. SPOUSE INFORMATION

His / Her Name: _____

Employer: _____ Occupation: _____

Wk #: (____) _____ Ext: _____ Cell #: (____) _____

Birth date: ____/____/____

Person Responsible for Account: ❒ Self ❒ Spouse

3. ORTHODONTIC INSURANCE

Primary:

Orthodontic coverage: ❒ Yes ❒ No Dental coverage: ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Primary Member ID#: _____

Insured's Name: _____ Relation: _____

Insured's Birth date: ____/____/____

Insured's Employer: _____

Secondary:

Orthodontic coverage: ❒ Yes ❒ No Dental coverage: ❒ Yes ❒ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Primary Member ID#: _____

Insured's Name: _____ Relation: _____

Insured's Birth date: ____/____/____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Wk #: (____) _____ Cell #: (____) _____

4. MEDICAL HISTORY

Do you have a personal physician? ❒ Yes ❒ No

Physician's Name: _____

Phone # (____) _____ Date of last visit: _____

Your current physical health is: ❒ Good ❒ Fair ❒ Poor
Are you currently under the care of a physician? ❒ Yes ❒ No
Please Explain: _____

Taking any prescription/over-the-counter drugs? ❒ Yes ❒ No

Please list each one: _____
_____

For women:
Are you using a prescribed method of birth control? ❒ Yes ❒ No
Are you pregnant? ❒ Yes ❒ No Week #: _____
Are you nursing? ❒ Yes ❒ No

Have you ever had any of the following diseases or medical problems?

❒ Yes ❒ No Abnormal Bleeding
❒ Yes ❒ No Anemia
❒ Yes ❒ No Asthma
❒ Yes ❒ No Arthritis
❒ Yes ❒ No Bulimia
❒ Yes ❒ No Blood Transfusion
❒ Yes ❒ No Kidney Problems
❒ Yes ❒ No Psychiatric Problems
❒ Yes ❒ No Radiation Treatment
❒ Yes ❒ No Shingles
❒ Yes ❒ No Glaucoma
❒ Yes ❒ No Heart Attack/Stroke
❒ Yes ❒ No Heart Murmur
❒ Yes ❒ No Herpes
❒ Yes ❒ No Hemophilia
❒ Yes ❒ No Hepatitis
❒ Yes ❒ No HIV+/AIDS
❒ Yes ❒ No Bone Disorders
❒ Yes ❒ No Diabetes
❒ Yes ❒ No Emphysema
❒ Yes ❒ No Difficulty Breathing
❒ Yes ❒ No Drug/Alcohol Abuse
❒ Yes ❒ No Fever Blisters
❒ Yes ❒ No Sinus Problems
❒ Yes ❒ No Tuberculosis (TB)
❒ Yes ❒ No Ulcers/Colitis
❒ Yes ❒ No Venereal Disease
❒ Yes ❒ No Artificial Bones/Joints/Valves
❒ Yes ❒ No High/Low Blood Pressure
❒ Yes ❒ No Hospitalized for Any Reason
❒ Yes ❒ No Cancer/Chemotherapy
❒ Yes ❒ No Congenital Heart Defect
❒ Yes ❒ No Mitral Valve Prolapse
❒ Yes ❒ No Rheumatic/Scarlet Fever
❒ Yes ❒ No Severe/Frequent Headaches
❒ Yes ❒ No Epilepsy/Seizures/Fainting
❒ Yes ❒ No Heart Surgery/Pacemaker

Please list any serious medical condition(s) that you have ever had:
_____

Ever taken Fosamax, or any other bisphosphonate? ❒ Yes ❒ No
Do you smoke or use tobacco in any form? ❒ Yes ❒ No
Have you ever taken Phen-Fen? ❒ Yes ❒ No

Are you allergic to any or the following:

Y N Aspirin
Y N Penicillin
Y N Erythromycin
Y N Codeine
Y N Dental Anesthetics
Y N Any Metals/Plastics
Y N Tetracycline
Y N latex

Please list any other drugs/materials that you are allergic to:
_____

5. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?
_____
_____

Have you ever had or been evaluated for orthodontic treatment? ❒ Yes ❒ No

Have you ever had a serious/difficult problem associated with any previous dental work? ❒ Yes ❒ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Your current dental health is: ❒ Good ❒ Fair ❒ Poor

Do you like your smile? ❒ Yes ❒ No

Gums ever bleed? ❒ Yes ❒ No

Have you ever had an injury to your: ❒ Mouth ❒ Teeth ❒ Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth? ❒ Yes ❒ No
If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? ❒ Yes ❒ No

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes the medical status. I authorize the dental staff to perform the necessary dental services the patient may need. This office reserves the right to verify the credit status of potential patients or responsible party/guardian of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office is HIPAA Compliant and is committed to meeting or exceeding the standers of infection control mandated by OSHA, the CDC and the ADA.

Signature: _____
Relation to patient: _____ Date: _____