Arleen Azar-Mehr, D.D.S., M.S.

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Today's Date_____

Tell Us About Yourself

Name:_____□Female □Male Age:_____ Date of Birth: _____□ Miss □ Ms □ Mrs □ Mr

Address:_____Unit #:_____City:_____State:_____Zip:_____SS#:_____

□ Own □ Rent How long there? _____□ Single □ Married □ Separated □ Divorced □ Widowed Person Responsible for this Account:_____

Home Phone #:(___)_____Work #:(___)_____Cell #:(___)_____Email:_____DL #:_____

Whom may we thank for referring you? _____Other family members seen by us:_____

General Dentist Name:_____DDS Phone #:(___)_____DDS Address:_____

Employer:_____Position:_____Employer Address:_____How long there?___

Spouse Information

Spouse's Name:_____Date of Birth:_____DL#:_____SS#:_____Email:_____

Employer:_____Position:_____Employer Address:_____How long there?_____

Orthodontic Insurance

Primary Insurance

Orthodontic Coverage □ Yes □ No Dental Coverage □ Yes □ No

Insurance Co Name:_____Insurance Phone #:_____Group #:_____

Insurance Address:_____City:_____State:_____Zip:_____

Insured's Name:_____Relation to Patient:_____Insured's Date of Birth:_____

Insured's ID#:_____Insured's SS#:_____Insured's Employer:_____

Secondary Insurance

Orthodontic Coverage □ Yes □ No Dental Coverage □ Yes □ No

Insurance Co Name:_____Insurance Phone #:_____Group #:_____

Insurance Address:_____City:_____State:_____Zip:_____

Insured's Name:_____Relation to Patient:_____Insured's Date of Birth:_____

Insured's ID#:_____Insured's SS#:_____Insured's Employer:_____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I agree and accept that this office reserves the right to verify credit status of potential patients and/or parents 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. I understand I am responsible for paying any co-payment and deductibles my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and, I assign directly to the doctor, all insurance benefits otherwise payable to me. I further authorize the use of my signature on all my insurance submissions, whether manual or electronic.

Signature **Date**

Dental & Medical History

What is your main concern ?_____

Are you happy with your smile? □ Yes □ No If not, what would you change?_____

Have you been evaluated or had orthodontic treatment before?	□ Yes □ No	Do you have any speech problems?	□Yes □ No
Have you ever had a serious problem in the past with dental work?	□ Yes □ No	Do you still have your wisdom teeth?	□Yes □ No
Have there been any injuries to your mouth/teeth/chin/face? (please circle)	□ Yes □ No	Do you have any missing or extra teeth?	□Yes □ No
Have you had any implants, pins or metal rods? (please circle)	□ Yes □ No	Do you require antibiotics prior to dental work?	□Yes □ No
Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)?	□ Yes □ No	Do you smoke or use tobacco in any other form?	□Yes □ No

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

Have you ever taken any diet pills, such as Phen-Fen? □ Yes □ No (Also known as Redux or Pondimin.) If so, when? _____

Please list all prescription and over the counter drugs that you are currently taking:_____

Do you have a personal physician? □ Yes □ No Name:_____Phone#:_____Date of Last Visit:_____

Are you currently under the care of a physician? □ Yes □ No If yes, please explain:_____

Please describe your current dental health: □ Good □ Fair □ Poor Please describe your current physical hea □ Good □ Fair □ Poor

For Women: Are you taking birth control? □ Yes □ No Are you pregnant? □ Yes □ No # of weeks:_____ Are you nursing? □ Yes □ No

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

Abnormal Bleeding	Y N	Fainting Spells	Y N	Pacemaker	Y N
AIDS	Y N	Frequent Headaches	Y N	Psychiatric Problems	Y N
Alcohol or Drug Abuse? (please circle)	Y N	Glaucoma	Y N	Radiation Treatment	Y N
Anemia	Y N	Hay Fever or Scarlet Fever (please circle)	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Heart Attack	Y N	Seizures	Y N
Artificial Bones/Joints/Valves (please circle)	Y N	Heart Murmur	Y N	Shingles	Y N
Asthma	Y N	Hepatitis: Type_____	Y N	Sickle Cell Disease	Y N
Blood Transfusion	Y N	Herpes or Fever Blisters (please circle)	Y N	Sinus Problems	Y N
Cancer: Type_____ Chemotherapy	Y N	High Blood Pressure	Y N	Stroke	Y N
Colitis	Y N	HIV	Y N	Surgery: for what_____	Y N
Congenital Heart Defect	Y N	Kidney Problems	Y N	Thyroid Problems	Y N
Diabetes	Y N	Liver Disease	Y N	Traits	Y N
Difficulty Breathing	Y N	Low Blood Pressure	Y N	Tuberculosis (TB)	Y N
Emphysema	Y N	Lupus	Y N	Ulcers	Y N
Epilepsy	Y N	Mitral Valve Prolapse	Y N	Venereal Disease	Y N

Please list any serious medical conditions or hospital stays that you have ever had:_____

Are you allergic to any of the following?

Aspirin	Y N	Erythromycin	Y N	Latex	Y N
Codeine	Y N	Jewelry	Y N	Penicillin	Y N
Dental Anesthetics	Y N	Metals	Y N	Tetracycline	Y N

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

I understand that all the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical or dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Patient Signature **Date**

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist Date

Dentist's Comments: _____

Has there been any change in your health status since your last visit? □ Y □ N

If Yes, please explain:_____

Patient Signature **Date**

Dentist Signature Date

Has there been any change in your health status since your last visit? □ Y □ N

If Yes, please explain:_____

Patient Signature **Date**

Dentist Signature Date