PHELPS & COHEN ORTHODONTICS

NEW PATIENT INFORMATION

www.PCOrtho.com
T (408) 298-3433 | F (408) 298-6304

DATE: _____

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Age: _____ ☐ Male ☐ Female

Address: _____

City, State Zip: _____

Home phone: _____

Cell phone: _____

Email: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired

Employer/School: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's name: _____

Who should we thank for referring you to our office?

_____

Has anyone else in your family been treated by our office?

_____

RESPONSIBLE PARTY INFORMATION

(If different from patient, complete below) ☐ Same as patient

Relationship ☐ Parent ☐ Grandparent ☐ Guardian ☐ Spouse

☐ Other: _____

Name: _____

DOB: _____ ☐ Male ☐ Female

Address: _____

City, State Zip: _____

Home phone: _____

Cell phone: _____

Email: _____

SSN: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired

Employer/School: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's name: _____

Spouse's email: _____

FAMILY INFORMATION (if patient is a child)

The following information is requested so that we can communicate properly with the people involved in your child's treatment.

With whom does the patient live (custodial parent)? _____

Who should receive routine information about treatment progress? _____

Who should receive financial information? _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Policy holder: _____

Employer: _____

Insured's SSN: _____

Insured's DOB: _____

Insured's Address (if different from patient's):

_____

_____

Insurance Company: _____

Insured's Member ID: _____

Insured's Group #: _____

SECONDARY DENTAL INSURANCE

Policy holder: _____

Employer: _____

Insured's SSN: _____

Insured's DOB: _____

Insured's Address (if different from patient's):

_____

_____

Insurance Company: _____

Insured's Member ID: _____

Insured's Group #: _____

PHELPS & COHEN ORTHODONTICS

HEALTH HISTORY

www.PhelpsCohenOrtho.com
T(408)-298-3433 F(408)298-6304

Patient Name: _____ DOB: _____ Age: _____

AIRWAY HISTORY

Do any of the following apply? *Please check "Yes" or "No"*

☐ Yes	☐ No	Mouth breathing (while awake)
☐ Yes	☐ No	Mouth breathing (while asleep)
☐ Yes	☐ No	Drooling during sleep
☐ Yes	☐ No	Snoring
☐ Yes	☐ No	Enuresis (bedwetting)
☐ Yes	☐ No	Morning headache
☐ Yes	☐ No	Restless sleep
☐ Yes	☐ No	Sleep talking
☐ Yes	☐ No	Sleepwalking
☐ Yes	☐ No	Daytime fatigue
☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Daytime sleepiness
☐ Yes	☐ No	Had a sleep study
☐ Yes	☐ No	Sleep apnea
☐ Yes	☐ No	Tonsil or adenoids removed
☐ Yes	☐ No	Anxiety
☐ Yes	☐ No	Depression
☐ Yes	☐ No	Learning or memory problems
☐ Yes	☐ No	Attention-deficit/hyperactivity disorder
☐ Yes	☐ No	Abnormal social interaction
☐ Yes	☐ No	Psychological withdrawn

DENTAL & TMJ HISTORY

Dentist: _____

Date of last cleaning: _____

Do any of the following apply? *Please check "Yes" or "No"*

☐ Yes	☐ No	Clenching or grinding of your teeth
☐ Yes	☐ No	Currently sucking thumb or finger
☐ Yes	☐ No	History of sucking thumb or finger
☐ Yes	☐ No	Tongue thrust
☐ Yes	☐ No	Speech problems
☐ Yes	☐ No	Missing or extra permanent teeth
☐ Yes	☐ No	Teeth removed by extraction
☐ Yes	☐ No	Past orthodontic treatment
☐ Yes	☐ No	TMJ pain
☐ Yes	☐ No	TMJ locking when opening or closing jaw
☐ Yes	☐ No	Clicking or popping jaw joint
☐ Yes	☐ No	Past TMJ treatment
☐ Yes	☐ No	Ringing in the ears or dizziness
☐ Yes	☐ No	Difficulty chewing or swallowing food
☐ Yes	☐ No	Bleeding gums when brushing or flossing
☐ Yes	☐ No	Sensitivity to cold, heat, sweets, or pressure

MEDICAL HISTORY

Are you currently being treated or have you been treated within the last year by a physician? ☐Yes ☐No

For what condition? _____

Are you taking or have you been taking any drugs or medications within the last year? ☐ Yes ☐ No

Please list: _____

Have you had a major illness or been hospitalized within the last 5 years? ☐ Yes ☐ No

Describe: _____

Are you allergic or sensitive to any of the following?

☐ Latex ☐ Nickel ☐ Penicillin

☐ Other: _____

Please check "Yes" or "No"

☐ Yes	☐ No	Cardiovascular disease/heart problems
☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Autism Spectrum disorder
☐ Yes	☐ No	Emotional/Nervous/Psychiatric care
☐ Yes	☐ No	Severe or frequent headaches
☐ Yes	☐ No	Fainting spells/convulsions
☐ Yes	☐ No	Ear/Sinus trouble
☐ Yes	☐ No	Endocrine problems
☐ Yes	☐ No	Diabetes

Premature birth: *Please check "yes" or "no"*

☐ Yes ☐ No

Is there any other information that might be important for us to know?

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

By entering your name, you acknowledge that you have been informed of Phelps & Cohen Orthodontics' Notice of Privacy Practices which is located on our website www.pcortho.com, under New Patients/Patient Forms . We may correspond with you via mail, email, text, and phone with the contact information you provide. Please notify the office if you choose to opt out of one of the communication methods or if your contact information changes. To refuse, enter REFUSED below.

I have been informed of Phelps & Cohen Orthodontics' Notice of Privacy Practices.

_____ _____

Patient Name (print) **Patient Signature or Parent/Guardian if patient is under 18 years**

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ **Individual refused to sign**

☐ **Communication barriers prohibited obtaining the acknowledgement**

☐ **An emergency situation prevented us for obtaining acknowledgement**

☐ **Other (please specify)**