PHELPS & COHEN ORTHODONTICS

NEW PATIENT INFORMATION

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

DATE: _____

PATIENT INFORMATION

Patient Name: _____

I like to be called: _____

DOB: _____ Age: _____ ☐ Male ☐ Female

Address: _____

City, State Zip: _____

Cell phone: _____

Home phone: _____

Email: _____

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

Employer/School: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's name: _____

Phone: _____

Email: _____

Who should we thank for referring you to our office?

_____

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

_____

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT **Need not be insurance policy holder(s)

☐ Self ☐ Parent ☐ Spouse ☐ Guardian

Name: _____

DOB: _____ ☐ Male ☐ Female

SSN: _____

Address: _____

City, State Zip: _____

Cell phone: _____

Home phone: _____

Email: _____

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

Employer/School: _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse name: _____

If divorced, what is the custody arrangement:

Mom:(_____%) _____

Dad:(_____%) _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Policyholder: _____

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

Policyholder: _____

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

PATIENT NAME:_____ **DOB:**_____ **AGE:**_____

AIRWAY HISTORY

Do any of the following apply? Pleas 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 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 Psychologically 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?_____

_____

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

Are you allergic or sensitive to any of the following?

☐ Latex ☐ Nickel ☐ Penicillin

☐ Other:_____

Please check "Yes" or "No"

☐ Yes ☐ No Cardiovascular disease/heart problem
☐ 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?

_____

_____

_____