Santelli ORTHODONTICS

"Creating Healthy and Beautiful Smiles"

Member American Association of Orthodontics

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Orthodontist

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BOCA RATON LOCATION
9930 Clint Moore Rd., Suite D102
Boca Raton, FL 33496

WELLINGTON LOCATION
3319 State Rd. 7, Suite 211
Wellington, FL 33449

1 PATIENT'S INFORMATION

Today's Date: _____

Name:_____
Last First MI Mr. Mrs. Ms. Dr.

I prefer to be called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ S/S#:_____

Home Address:_____

_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Hm#:_____ Cell#: _____

Wk#:_____ Ext:____

Email: _____

DL#: _____

Employer:_____

Employer's Address: _____

How long there?_____ Occupation:_____

Where & when are the best times to reach you _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

Last visit date: _____

2 PARENT or SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Wk#:_____ Ext:_____ S/S#: _____

Birthdate: ____/____/____

3 YOUR CHILDREN

NAME OF CHILD BIRTHDATE

_____/____/____

_____/____/____

_____/____/____

_____/____/____

Do they live with you? ❑ yes ❑ No

4 ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage: ❑ yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name:_____Relation:_____

Insured's Birthdate: ____/____/____ Insured's SS :_____

Insured's Employer: _____

SECONDARY

Orthodontic Coverage: ❑ yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name:_____Relation:_____

Insured's Birthdate: ____/____/____ Insured's SS :_____

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 #:_____ Hm #: _____

Person responsible for the account: _____

Wk #:_____ Ext:_____ Hm #: _____

Billing Address:_____

Zip

Relation:_____ S/S: _____

Employer:_____ DL #: _____

5 MEDICAL HISTORY

Do you have a personal physician? ❑ yes ❑ No

Physician's Name: _____

Phone #:_____ Date of last visit: _____

6 MEDICAL HISTORY continued

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain:_____

Are you taking any prescription/over the counter drugs: ❑ Yes ❑ No

Please list each one: _____

For women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #_____

Are you nursing? ❑ Yes ❑ No

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

Y N	Anaemia/Radiation Treatment	Y N	Heart Surgery/Pacemaker
Y N	Artificial Bones/Joints	Y N	Haemaphilia/Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma/Arthritis	Y N	High/Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV + AIDS
Y N	Cancer/Chemotherapy	Y N	Hospitalized for Any Reason
Y N	Congenital Heart Disease	Y N	Kidney Problems
Y N	Diabetes/Tuberculosis	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug/Alcohol Abuse	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema/Glaucoma	Y N	Severe/Frequent Headaches
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Epilepsy/Seizures/Fainting Spells
Y N	Fever Blisters/Herpes	Y N	Shingles
Y N	Heart Attack/Stroke	Y N	Ulcers/Colitis
Y N	Heart Murmur	Y N	Venereal Disease

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

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metal/Plastic	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

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

_____

_____

7 ORTHODONTIC INSURANCE

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

_____

_____

Have you ever 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

Do your 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 breath through your mouth? ❑ Awake? ❑ Asleep?
(Please Check One)

Do you have any missing or extra permanent Teeth? ❑ Yes ❑ No

7 REFERENCES

Do you know of any other family member or friend who would benefit from orthodontic treatment? ❑ yes ❑ No

Name	Phone Number
_____	_____
_____	_____

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held by the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

! THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

This office reserves the right to verify the credit status of potential patients and / 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.

_____
Signature Date

! OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient names herein. Initials:_____ Date: _____

Doctor's Comments:

_____

_____

_____