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**DOUGLAS C. KALLIS DMD · PC**  
*Orthodontics Exclusively*

Date \_\_\_\_\_

A B C

**PATIENT INFORMATION** E-MAIL: \_\_\_\_\_

NAME \_\_\_\_\_ SEX:  M  F  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE ( ) \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
LAST FIRST MIDDLE

RESIDENCE \_\_\_\_\_  
STREET CITY STATE ZIP

MAILING ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOW LONG AT THIS ADDRESS? \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ YEARS EMPLOYED \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ YEARS EMPLOYED \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

**INSURANCE INFORMATION**

INSURED'S NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
LAST FIRST MIDDLE

EMPLOYER'S NAME \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP# \_\_\_\_\_ LOCAL# \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

DO YOU HAVE DUAL COVERAGE? \_\_\_\_\_ IF YES: \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
LAST FIRST MIDDLE

EMPLOYER'S NAME \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ LOCAL # \_\_\_\_\_

INSURANCE COMPANY ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

**EMERGENCY INFORMATION**

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

COMPLETE ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME PHONE ( ) \_\_\_\_\_ SPECIAL NOTES \_\_\_\_\_

**MEDICAL HISTORY**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> HIV Infection             |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Emotional Problems          | <input type="checkbox"/> Kidney Disorders          |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Endocrine Disorders         | <input type="checkbox"/> Latex Sensitivity         |
| <input type="checkbox"/> Artificial Heart Valve   | <input type="checkbox"/> Epilepsy (Convulsions)      | <input type="checkbox"/> Liver Disease             |
| <input type="checkbox"/> Artificial Joints        | <input type="checkbox"/> Frequent Headaches          | <input type="checkbox"/> Mitral Valve Prolapse     |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Neurologic Disorders      |
| <input type="checkbox"/> Blood Disorders          | <input type="checkbox"/> Heart Murmur/Heart Problems | <input type="checkbox"/> Respiratory Problems      |
| <input type="checkbox"/> Blood Transfusions       | <input type="checkbox"/> Hemophilia                  | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Bruise Easily            | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Cerebral Palsy           | <input type="checkbox"/> Herpes                      | <input type="checkbox"/> Tonsil or Adenoid Removal |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Tuberculosis              |

YOUR PHYSICIAN \_\_\_\_\_

STATE ANY REASONS WHY YOU ARE CURRENTLY UNDER THE CARE OF A PHYSICIAN \_\_\_\_\_

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING \_\_\_\_\_

LIST ANY DRUG ALLERGIES OR SENSITIVITIES \_\_\_\_\_

HAVE YOU BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES? (YES OR NO) \_\_\_\_\_

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE \_\_\_\_\_

**DENTAL HISTORY**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bleeding Gums                    | <input type="checkbox"/> Jaw Joint Pain                   | <input type="checkbox"/> Nail Biting                  |
| <input type="checkbox"/> Chronic Facial Pain              | <input type="checkbox"/> Jaw Joints Pop or Click          | <input type="checkbox"/> Periodontal Surgery          |
| <input type="checkbox"/> Clenching or Grinding of Teeth   | <input type="checkbox"/> Jaw Locking Open or Closed       | <input type="checkbox"/> Permanent Teeth Removed      |
| <input type="checkbox"/> Difficulty Chewing or Swallowing | <input type="checkbox"/> Limitation in Mouth Opening      | <input type="checkbox"/> Speech Problems              |
| <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Missing or Extra Permanent Teeth | <input type="checkbox"/> Sucks Thumb, Finger or Lip   |
| <input type="checkbox"/> Frequent Headaches               | <input type="checkbox"/> Mouth Breathing                  | <input type="checkbox"/> Teeth Sensitivity - Hot/Cold |
| <input type="checkbox"/> Injuries to Face or Teeth        | <input type="checkbox"/> Muscle Tenderness in Jaw or Neck | <input type="checkbox"/> Tongue Thrust                |

YOUR DENTIST \_\_\_\_\_

LIST ANY DENTAL PROBLEMS WE SHOULD KNOW ABOUT \_\_\_\_\_

HAVE YOU RECEIVED AN EVALUATION OR TREATMENT IN ANOTHER ORTHODONTIC OFFICE? (YES OR NO) \_\_\_\_\_

IF YES, BY WHOM? \_\_\_\_\_

LIST YOUR CHIEF CONCERNS AND WHAT YOU WOULD LIKE THIS ORTHODONTIC TREATMENT TO ACCOMPLISH \_\_\_\_\_

**AUTHORIZATION**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my care. I authorize Dr. Kallis and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment.

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

FOR OFFICE USE  
UPDATES (DATE AND INITIAL)