Member
American Association of Orthodontists

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DOUGLAS C. KALLIS DMD · PC

Orthodontics Exclusively

Date

A B C

PATIENT INFORMATION

E-MAIL: _____

PATIENT'S 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? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

NAME _____ MARITAL STATUS _____
LAST FIRST MIDDLE

RESIDENCE _____ ☐ RENT ☐ OWN
STREET CITY STATE ZIP

MAILING ADDRESS _____
STREET CITY STATE ZIP

HOW LONG
AT THIS ADDRESS? _____ PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ CELL PHONE (_____) _____

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 _____ BIRTHDATE _____

INSURANCE COMPANY _____ GROUP # _____ MEMBER ID # _____

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 _____ BIRTHDATE _____

INSURANCE COMPANY _____ GROUP # _____ MEMBER ID # _____

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")

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

◇ Bleeding Gums	◇ Jaw Joint Pain	◇ Nail Biting
◇ Chronic Facial Pain	◇ Jaw Joints Pop or Click	◇ Periodontal Surgery
◇ Clenching or Grinding of Teeth	◇ Jaw Locking Open or Closed	◇ Permanent Teeth Removed
◇ Difficulty Chewing or Swallowing	◇ Limitation in Mouth Opening	◇ Speech Problems
◇ Dizziness	◇ Missing or Extra Permanent Teeth	◇ Sucks Thumb, Finger or Lip
◇ Frequent Headaches	◇ Mouth Breathing	◇ Teeth Sensitivity – Hot/Cold
◇ Injuries to Face or Teeth	◇ Muscle Tenderness in Jaw or Neck	◇ 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)