SHIMIZU ORTHODONTICS

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877 WEST FREMONT AVENUE, SUITE G-1 • SUNNYVALE, CA 94087 • PHONE (408) 738-1314 • SHIMIZUORTHO.COM

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE AND EMAIL TO US PRIOR TO YOUR INITIAL ORTHODONTIC EXAMINATION APPOINTMENT

## ABOUT YOU

Today's Date _____

Name _____ Please Circle: Mr. Mrs. Ms. Dr.

I prefer to be called _____ Birthdate _____ Age _____

Home address _____ Apt. # _____
*Street Address*

_____ Years at this address _____
*City* *State* *Zip Code*

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Soc Sec # _____ Cell # _____ Work #_____ Ext. _____

Email _____

Employer_____ Years Employed _____ Occupation _____

Whom may we thank for referring you to our office? _____

Other family members seen by us _____

Who will be financially responsible for your treatment? _____

## SPOUSE INFORMATION

His/her Name _____ Please Circle: Mr. Mrs. Ms. Dr.

Home address _____ Apt. # _____
(If different from Above) *Street Address*

_____ Years at this address _____

Birthdate _____

Employer_____ Years Employed _____ Occupation _____

Home # _____ Cell # _____ Work #_____ Ext. _____

Email _____

## ORTHODONTIC INSURANCE

Is Orthodontic Coverage Available? ☐ Yes ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Member ID# or SSN _____

Is Secondary or Dual Insurance Coverage Available? ☐ Yes ☐ No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Member ID# or SSN _____

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Please continue

## DENTAL INFORMATION

Current Dentist's Name _____ City _____ Date of Last Visit _____

Date of Last X-Rays _____ Type _____ Are you Currently Experiencing Dental Pain? _____

Have You Ever Had or Experienced Any of The Following?

- ☐ Teeth sensitive to hot, cold, sweets or pressure
- ☐ Traumatic injury to teeth or mouth
- ☐ Pain or tenderness around ear, joint, or side of face
- ☐ Pain, Swelling, or Bleeding of Gums
- Difficulty in: ☐ Opening / closing ☐ Chewing ☐ Swallowing ☐ Speaking
- ☐ Clicking or popping of jaw joint
- ☐ Clenching or grinding of teeth
- ☐ Periodontal treatment
- ☐ TMJ / Splint treatment
- ☐ Ulcers / Cold sores
- ☐ Pain, swelling, or bleeding gums
- ☐ Loosening of Permanent teeth

Oral habits:

- ☐ Thumb or finger sucking
- ☐ Lip / Cheek biting ☐ Nail biting
- ☐ Mouth breathing ☐ Tongue thrust

If Yes, please explain _____

Are you nervous about having dental treatment? _____

## MEDICAL INFORMATION

Physician's Name _____ Date of Last Medical Exam _____

Address _____ Phone # _____

If currently under a Physician's care, for what reasons? _____

If taking any medications, please list: _____

Are you allergic to any medications: _____ Latex allergy? _____

Do you require any medications prior to dental work? _____

Have you Had or Do You have Any of the Following: (check if "Yes")

- ☐ Heart Disease
- ☐ Abnormal Blood Pressure
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Anemia
- ☐ Ulcers
- ☐ Tuberculosis / Lung disease
- ☐ Venereal Disease
- ☐ Hepatitis / Liver Problems
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Communication disorder
- ☐ Epilepsy
- ☐ Frequent Headaches
- ☐ Nervous Disorders
- ☐ Cancer or Leukemia
- ☐ Radiation Therapy
- ☐ H.I.V. Positive
- ☐ Bone Disorders
- ☐ Allergies
- ☐ Sinus trouble
- ☐ Hay fever
- ☐ Herpes
- ☐ Hearing disability
- ☐ Learning disorder
- ☐ Growth disorders

If yes, please explain _____

## ORTHODONTIC INFORMATION

What is your primary concern about your teeth? _____

How would you like us to correct the problem? _____

Do you have any concerns about orthodontic treatment? _____

Have you had other Orthodontic consultations / treatment? _____ Orthodontist _____

Please describe _____

Have other family members had orthodontic treatment? _____ Orthodontist _____

Please describe _____

Is there any additional information you would like us to know? _____

*Please email this completed form to info@shimizuortho.com prior to your first appointment.*
*We look forward to meeting you!*

Signed _____ Date _____ Reviewed by _____