PRIMROSE ORTHODONTICS
(626) 285-5800 | info@primroseortho.com
9531 Las Tunas Dr, Temple City, CA 91780

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ / _____ / _____ SSN#: _____ Sex: M / F / Other

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Responsible Party if Minor: _____ SSN#: _____

Referred by: _____

GENERAL DENTIST INFORMATION

Patient's Dentist: _____ Phone Number: _____

Last Seen Date: _____ Why: _____

Address: _____

City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

Patient Name: _____

Primary Policy Holder Name: _____ Relationship to Patient: _____

Date of Birth: _____ / _____ / _____ SSN# Policy Holder:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Employer: _____ Primary Carrier Name: _____

Group Number: _____ Policy No: _____

Does this Policy have orthodontic benefits? YES: _____ NO: _____ DONT KNOW _____

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Patient: _____ Date: _____

Birthdate: _____ Age: _____ [ ] Male [ ] Female [ ] Other

MEDICAL HISTORY

☐yes ☐no ☐dk/u Birth defects or hereditary problems?
☐yes ☐no ☐dk/u Bone fractures, any major accidents?
☐yes ☐no ☐dk/u Rheumatoid or arthritic conditions
☐yes ☐no ☐dk/u Endocrine or thyroid problems?
☐yes ☐no ☐dk/u Kidney problems?
☐yes ☐no ☐dk/u Diabetes?
☐yes ☐no ☐dk/u Cancer or been treated for a tumor?
☐yes ☐no ☐dk/u Stomach ulcer or hyperacidity?
☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐yes ☐no ☐dk/u Problems of the immune system?
☐yes ☐no ☐dk/u Hepatitis, jaundice or liver problem?
☐yes ☐no ☐dk/u AIDS or HIV Positive?
☐yes ☐no ☐dk/u Sexually transmitted disease?
☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurologic disease?
☐yes ☐no ☐dk/u Mental health or behavioral problems
☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?
☐yes ☐no ☐dk/u Loss of weight recently, poor appetite?
☐yes ☐no ☐dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
☐yes ☐no ☐dk/u High or low blood pressure?
☐yes ☐no ☐dk/u Easily tired?
☐yes ☐no ☐dk/u Chest pain, shortness of breath or swelling ankles?
☐yes ☐no ☐dk/u Skin disorder?
☐yes ☐no ☐dk/u Do you have a normal and good diet?

☐yes ☐no ☐dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
☐yes ☐no ☐dk/u Frequent headaches, colds or sore throats?
☐yes ☐no ☐dk/u Any history of speech problems?
☐yes ☐no ☐dk/u Eye, ear, nose, throat condition?
☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble, hives?
☐yes ☐no ☐dk/u Tonsil or adenoid conditions?
☐yes ☐no ☐dk/u Allergies or drug reactions?
Describe: _____
☐yes ☐no ☐dk/u Are you taking medication, nutrient supplements or non prescription medicine? Please name them:
_____
☐yes ☐no ☐dk/u Do you currently have or ever had a substance abuse problem?
☐yes ☐no ☐dk/u Operations?
Describe: _____
☐yes ☐no ☐dk/u Hospitalized?
Describe: _____
☐yes ☐no ☐dk/u Other physical problems or symptoms?
Describe: _____
☐yes ☐no ☐dk/u Being treated by another health care professional?
Describe: _____
☐yes ☐no ☐dk/u Are you in good health?
Date of most recent physical exam? _____

FEMALE PATIENT

☐yes ☐no ☐dk/u Are you pregnant?
☐yes ☐no ☐dk/u Are you taking birth control pills?
☐yes ☐no ☐dk/u Are you anticipating becoming pregnant?

Medications and Dosage: _____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

_____ _____

Patient / Responsible Party Signature Date