WELCOME TO THE ORTHODONTIC PRACTICE OF

# Dr. Hani Thariani

## 1 ABOUT YOU

TODAY'S DATE: _____

NAME: _____
LAST FIRST MI

I PREFER TO BE CALLED: _____

☐ M ☐ F BIRTHDATE: _____/_____/_____ AGE: _____

HOME ADDRESS: _____

_____
CITY STATE ZIP

☐ SINGLE ☐ PARTNERED ☐ DIVORCED ☐ MARRIED ☐ SEPARATED ☐ WIDOWED

WORK #: _____ HOME #: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

_____
CITY STATE ZIP

LENGTH AT CURRENT JOB: _____ OCCUPATION: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

LIST OTHER FAMILY MEMBERS SEEN BY US: _____

_____

GENERAL DENTIST: _____

DATE OF LAST VISIT: _____

## 2 SPOUSE INFORMATION

HIS/HER NAME: _____

EMPLOYER: _____

WORK #: _____ BIRTHDATE: _____/_____/_____

## 3 PRIMARY DENTAL INSURANCE

**ORTHODONTIC COVERAGE?** YES ☐ NO ☐ I DON'T KNOW ☐

INSURANCE COMPANY: _____

DENTAL CLAIM'S ADDRESS: _____

_____

POLICYHOLDER'S NAME: _____

POLICYHOLDER'S BIRTHDATE: ___/___/___ ID #: _____

IF ID# IS UNKNOWN, PLEASE PROVIDE POLICYHOLDER'S SS#

POLICYHOLDER'S SS#: _____

GROUP #: _____

EMPLOYER: _____

RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S HOME ADDRESS (IF DIFFERENT FROM CHILD'S):

_____

_____

## 4 HEALTH HISTORY

**WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH?**

_____

_____

**Y N** HAVE YOU EVER BEEN EVALUATED FOR ORTHODONTIC TREATMENT

**- IF YES,** AND TREATMENT WAS RECOMMENDED,

WAS TREATMENT STARTED? **Y N**

PLEASE ELABORATE: _____

_____

**Y N** HAVE YOU EVER HAD A SERIOUS / DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK?

**Y N** DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN / DISCOMFORT IN YOUR JAW JOINT (TMJ/TMD)?

**Y N** DO YOU HAVE ANY MISSING OR EXTRA PERMANENT TEETH?

**Y N** DO YOU LIKE YOUR SMILE?

**Y N** DO YOUR GUMS BLEED?

YOUR CURRENT DENTAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

HAVE YOU EVER HAD AN INJURY TO YOUR: ☐ MOUTH ☐ TEETH ☐ CHIN

INDICATE ANY SPEECH PROBLEMS: _____

DO YOU BREATHE THROUGH YOUR MOUTH? ☐ WHILE AWAKE ☐ WHILE ASLEEP

**WOMEN:** ARE YOU PREGNANT OR NURSING? ☐ YES ☐ NO

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

**Y N** LATEX **Y N** METALS/NICKEL **Y N** PLASTICS

PLEASE DISCUSS ANY OTHER ALLERGIES OR MEDICAL CONDITIONS THAT YOU WOULD LIKE OUR OFFICE TO BE AWARE OF: _____

_____

## !

I understand that the information that I have given is correct to the best of my knowledge, that it will be held to the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need.

I understand that I am responsible for payment of services rendered and that I am responsible for any payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____
SIGNATURE DATE