MEDICAL HISTORY FORM

CASTRO VALLEY Orthodontics
Susan S. So D.M.D., M.M.Sc.

(PLEASE PRINT)

Today's date (MM/DD/YYYY):						
PATIENT INFORMATION						
❑ Mr. ❑ Mrs. ❑ Ms.	Patient's last name:	First:	Middle:	Birth date:	Age	Gender
				/ /		❑ F ❑ M
Name you like to be called?	Do you play a musical instrument?	If YES, which instrument?				
	❑ NO❑ YES					
Mailing Address:	City:	State	ZIP:			
Home Phone	Work Phone	Cell Phone	Email address:			
( )- -	( )- -	( )- -				
Employer	No. of years employed	Occupation	Social Security No.			
			- -			
How did you hear about our office?	❑ Dr.	❑ Family	❑ Friend	❑ Website/Internet		
❑ Insurance	❑ Close to home/work	❑ Yellow Pages	❑ Other:			
Other family members seen here:						
Who may we thank for referring you to our office?						
RESPONSIBLE PARTY				**❑ SAME AS ABOVE**		
❑ Mr. ❑ Mrs. ❑ Ms.	Last Name	First	Middle	Marital Status		
				❑ Married ❑ Single ❑ Divorced ❑ Widowed		
Social security No.	Date of Birth	Home Phone	Work Phone	Cell Phone		
		( )- -	( )- -	( )- -		
Address:	State	ZIP	Years at this address			
Mailing Address (if different from above)	State	ZIP				
Previous Address (if less than 3 years)	State	ZIP				
Employer	Occupation	No. of years employed	Spouse's name:			
PRIMARY INSURANCE						
Insured person's name						
	Insured Social security No.	Insurance Company				
Insurance Company address	- -					
		State	ZIP			
Insurance Company Phone:						
( )- -	Insured's Employer:	Group No.				

Secondary Insurance			
Insured person's name	Insured Social security No.	Insurance Company	
	- -		
Insurance Company address		State	ZIP
Insurance Company Phone:	Insured's Employer:		Group No.
( ) - -			

MEDICAL HISTORY

Physician Name:	Phone:	Dentist Name:	Phone:
	( ) - -		( ) - -

Are you currently under any medical treatment?	❑ NO ❑ YES	Other major illness, condition, surgery or problem not listed?	❑ NO ❑ YES
Do you have pain, clicking, and/or popping noises in the jaw?	❑ NO ❑ YES	If yes, please list:	
Are you aware of either clenching or grinding of teeth?	❑ NO ❑ YES	Do you bleed easily?	❑ NO ❑ YES
Do you have frequent headaches?	❑ NO ❑ YES	Is there a tendency to faint or become dizzy?	❑ NO ❑ YES
How often?		Do you have allergies? (Latex, sulphur, penicillin, novocaine, etc.)	❑ NO ❑ YES
Do you have ear problems? (Aches, ringing, dizziness, fullness)	❑ NO ❑ YES	If yes, please list:	
Do you have difficulty breathing through the nose?	❑ NO ❑ YES	Are you currently taking any medication?	❑ NO ❑ YES
Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?	❑ NO ❑ YES	If yes, please list:	
Have you had your tonsils and / or adenoids removed?	❑ NO ❑ YES	Have you ever taken any weight loss mediaction (e.g., PhenFen)?	❑ NO ❑ YES
Do you have speech problems or are you in speech therapy?	❑ NO ❑ YES	Have you ever taken i.v. Biphosphonates or oral Biphosphonates (i.e., Boniva)?	❑ NO ❑ YES
Do you have sleep apnea?	❑ NO ❑ YES	Do you have a heart murmur?	❑ NO ❑ YES
Has there been any history of:		Do you pre-medicate?	❑ NO ❑ YES
Joint swelling ❑ NO ❑ YES Aids ❑ NO ❑ YES		Are you pregnant?	❑ NO ❑ YES
Asthma ❑ NO ❑ YES Liver Condition ❑ NO ❑ YES		Do you smoke or chew tobacco?	❑ NO ❑ YES
TB ❑ NO ❑ YES Epilepsy ❑ NO ❑ YES		Have there been any injuries to the teeth	❑ NO ❑ YES
Kidney ❑ NO ❑ YES Rheumatic fever ❑ NO ❑ YES		Were any teeth removed by extractions?	❑ NO ❑ YES

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( ) - -	( ) - -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Iris Kohlmann. I understand that I am financially responsible for any balance. I also authorize Dr. Susan So or an insurance company to release any information required to process my claims. I understand that a credit report may be obtained prior to accepting a payment plan.

Patient/Guardian signature	*Date*
Reviewed by	*Date*
Reviewed by	*Date*
Reviewed by	*Date*