KUBO ORTHODONTIC GROUP
A DENTAL CORPORATION

DATE: ___/___/___

WELCOME
To Our Orthodontic Office

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.

INFORMATION BELOW *MUST* BE FILLED OUT COMPLETELY

ABOUT YOU

Name _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Whom can we thank for referring you? _____

Home Address _____ City _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email _____ Date of Birth ___/___/___

Would you like to receive appointment reminders ☐ Yes ☐ No If Yes, please circle: Phone Email

Employer Name _____ Occupation _____

Employer Address _____ City _____ Zip _____

Social Security # ___/___/___ Drivers License # _____

SPOUSE INFORMATION

Name _____ Date of Birth ___/___/___

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Employer Name _____ Occupation _____

Social Security # ___/___/___ Driver's License # _____ Email _____

ORTHODONTIC INSURANCE

Policy Holder's Name _____

Date of Birth ___/___/___ ID# (mandatory for insurance billing) _____

Employer Name _____

Name of Insurance Company _____ Insurance Company Address _____

City _____ State _____ Zip _____

Policy Holder's Relationship to Patient _____ Group or Plan # _____

SECONDARY ORTHODONTIC INSURANCE

Policy Holder's Name _____

Date of Birth ___/___/___ ID# (mandatory for insurance billing) ___/___/___

Employer Name _____

Name of Insurance Company _____ Insurance Company Address _____

City _____ State _____ Zip _____

Policy Holder's Relationship to Patient _____ Group or Plan # _____

In the event of an emergency, is there someone who lives near that we should contact?

His/Her Name _____ Relation _____

Work # _____ Home # _____

Continued on back

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name _____

Phone # (____) _____ Date of last visit _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain _____

Are you taking any prescription and/or over-the-counter drugs? ☐ Yes ☐ No

Please list each one _____

_____

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? (If yes, week #_____) ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N	Anemia/Radiation Treatment	Y N	Heart Surgery/Pacemaker
Y N	Artificial Bones/Joints	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma/Arthritis	Y N	High/Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV+/AIDS
Y N	Cancer/Chemotherapy	Y N	Hospitalized for any Reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes/Tuberculosis (TB)	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug/Alcohol Abuse	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema/Glaucoma	Y N	Severe/Frequent Headaches
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Shingles
Y N	Fever Blisters/Herpes	Y N	Sinus Problems
Y N	Heart Attack/Stroke	Y N	Ulcers/Colitis
Y N	Heart Murmur	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Any Metal/Plastic	Y N	Erythromycin	Y N	Tetracycline
Y N	Codeine	Y N	Latex	Y N	Other

Please list any other drugs that you are allergic to:_____

_____

_____

General Dentist _____

Telephone # _____

Date of last visit _____

DENTAL HISTORY

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had an injury to your ☐ Mouth ☐ Teeth ☐ Chin

Do you have any speech problems? _____

_____

Do you generally breathe through your mouth? ☐ Yes ☐ No

When awake? ☐ Yes ☐ No

When asleep? ☐ Yes ☐ No

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

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

_____

Signature Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Comments: Initials:_____ Date:_____

_____

_____

_____

_____

_____