CONFIDENTIAL PATIENT INFORMATION – ADULT

Rave ORTHODONTICS DR. RAVASSIPOUR

Patient Name _____ Goes By_____
Date of Birth _____ Email _____ Home Phone _____
Cell Phone _____Cell Carrier_____ General Dentist _____
Address, City, State, Zip _____
What is your main concern regarding the patient's teeth and jaws? _____
_____
Whom may we thank for your referral? _____
Family history of orthodontics _____
Relatives or family treated here _____

MEDICAL HISTORY

Describe the patient's health _____
Does he/she have any medical problems? Under any medical treatment now? ◯ Yes ◯ No
Please describe _____
Circle any of the following which the patient has experienced:

☐ Pre-medication necessary	☐ Asthma	☐ Prolonged bleeding/anemia
☐ Heart trouble/murmur	☐ Glaucoma	☐ Rheumatic fever
☐ Drug Allergies	☐ Epilepsy	☐ Fainting or dizziness
☐ Diabetes	☐ Allergies	☐ HIV or AIDS
☐ Nervous disorders/ADHD	☐ Hepatitis	☐ Other

Please describe any above circled _____
Bisphosphonate medications taken/taking _____
Any over the counter medications _____

DENTAL HISTORY

Have there been any injuries to your face, mouth or teeth? ◯ Yes ◯ No
Please describe _____
Are you aware of any missing or extra teeth? ◯ Yes ◯ No
Please describe _____
Did you have any oral habits, like sucking a thumb? If so, until what age? _____
_____
Do you breath predominantly through your mouth? ◯ Yes ◯ No
Do you clinch or grind your teeth or have jaw pains or clicking? ◯ Yes ◯ No
Have you had previous orthodontic treatment? _____
When did you last visit the dentist? _____

PERSONAL HISTORY

Hobbies or special interests _____
Is there any other information that we should know? If so, please comment: _____
_____

Please complete the reverse side also.

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Mailing Address _____
Residence _____
How long at this address? _____ Home Phone _____ Cell Phone _____
Previous Address (if less than 3 yrs.) _____
Social Security # _____ Birthdate _____ Relationship to patient _____
Employer _____ Occupation _____ # Years Employed _____
Spouse's Name _____ Relationship to patient _____
Employer _____ Occupation _____ # Years Employed _____
Social Security # _____ Birthdate _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ ID # _____
Insurance Company _____ Group # _____ Union Loc. # _____
Insurance Co. Address _____ Insurance Co. Phone _____
Policy Holder's Employer _____
Do you have dual coverage? ◯ No ◯ Yes If yes, please complete below:
Policy Holder's Name _____ Soc. Sec. # _____
Insurance Company _____ Group # _____ Union Loc. # _____
Insurance Co. Address _____ Insurance Co. Phone _____
Policy Holder's Employer _____

EMERGENCY INFORMATION

Emergency Contact Person _____
Complete Address _____
Phone Number _____ Relationship to Patient _____

AUTHORIZATION

I authorize the release of medical and dental information to insurance carriers and to other health care providers involved in the care of this patient and the use of the records by Dr. Ravassipour for teaching purposes and scientific publication, and credit bureau reports as necessary. In the future, please advise Dr. Ravassipour of any changes in your medical or dental health while under the care of our office. Cell phone and carrier information is used to confirm appointments.

Thank you.

_____ _____
Signature Date