



# Arleen Azar-Mehr, D.D.S., M.S.

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Today's Date \_\_\_\_\_

## Tell Us About Yourself

Name: \_\_\_\_\_  Female  Male Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Miss  Ms  Mrs  Mr  
 Address: \_\_\_\_\_ Unit #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Own  Rent How long there? \_\_\_\_\_  Single  Married  Separated  Divorced  Widowed Person Responsible for this Account: \_\_\_\_\_  
 Home Phone #:(\_\_\_\_) \_\_\_\_\_ Work #:(\_\_\_\_) \_\_\_\_\_ Cell #:(\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_ DL #: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_ Other family members seen by us: \_\_\_\_\_  
 General Dentist Name: \_\_\_\_\_ DDS Phone #:(\_\_\_\_) \_\_\_\_\_ DDS Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Employer Address: \_\_\_\_\_ How long there? \_\_\_\_\_

## Spouse Information

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ DL#: \_\_\_\_\_ SS#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Employer Address: \_\_\_\_\_ How long there? \_\_\_\_\_

## Orthodontic Insurance

### Primary Insurance

Orthodontic Coverage  Yes  No Dental Coverage  Yes  No  
 Insurance Co Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
 Insured's ID#: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

### Secondary Insurance

Orthodontic Coverage  Yes  No Dental Coverage  Yes  No  
 Insurance Co Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
 Insured's ID#: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

**Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

### Payment is due in full at the time of treatment unless prior arrangements have been approved.

I agree and accept that this office reserves the right to verify credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered. I understand I am responsible for paying any co-payment and deductibles my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and, I assign directly to the doctor, all insurance benefits otherwise payable to me. I further authorize the use of my signature on all my insurance submissions, whether manual or electronic.



Signature \_\_\_\_\_

Date \_\_\_\_\_

**Dental & Medical History**

What is your main concern? \_\_\_\_\_

Are you happy with your smile?  Yes  No      If not, what would you change? \_\_\_\_\_

Have you been evaluated or had orthodontic treatment before?  Yes  No      Do you have any speech problems?  Yes  No

Have you ever had a serious problem in the past with dental work?  Yes  No      Do you still have your wisdom teeth?  Yes  No

Have there been any injuries to your mouth/teeth/chin/face? (please circle)  Yes  No      Do you have any missing or extra teeth?  Yes  No

Have you had any implants, pins or metal rods? (please circle)  Yes  No      Do you require antibiotics prior to dental work?  Yes  No

Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)?  Yes  No      Do you smoke or use tobacco in any other form?  Yes  No

Do you generally breathe through your mouth?  Yes  No      If yes, please circle:    While Awake?    While Asleep?

Have you ever taken any diet pills, such as Phen-Fen?  Yes  No (Also known as Redux or Pondimin. ) If so, when? \_\_\_\_\_

Please list all prescription and over the counter drugs that you are currently taking: \_\_\_\_\_

Do you have a personal physician?  Yes  No    Name: \_\_\_\_\_    Phone#: \_\_\_\_\_    Date of Last Visit: \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No    If yes, please explain: \_\_\_\_\_

Please describe your current dental health:     Good  Fair  Poor      Please describe your current physical health:  Good  Fair  Poor

**For Women:** Are you taking birth control?  Yes  No      Are you pregnant?  Yes  No    # of weeks: \_\_\_\_\_      Are you nursing?  Yes  No

**Have you ever had any of the following diseases or medical problems?**

Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Pacemaker	Y	N
AIDS	Y	N	Frequent Headaches	Y	N	Psychiatric Problems	Y	N
Alcohol or Drug Abuse? (please circle)	Y	N	Glaucoma	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Hay Fever or Scarlet Fever (please circle)	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Seizures	Y	N
Artificial Bones/Joints/Valves (please circle)	Y	N	Heart Murmur	Y	N	Shingles	Y	N
Asthma	Y	N	Hepatitis: Type _____	Y	N	Sickle Cell Disease	Y	N
Blood Transfusion	Y	N	Herpes or Fever Blisters (please circle)	Y	N	Sinus Problems	Y	N
Cancer: Type _____ Chemotherapy	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Colitis	Y	N	HIV	Y	N	Surgery: for what _____	Y	N
Congenital Heart Defect	Y	N	Kidney Problems	Y	N	Thyroid Problems	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Traits	Y	N
Difficulty Breathing	Y	N	Low Blood Pressure	Y	N	Tuberculosis (TB)	Y	N
Emphysema	Y	N	Lupus	Y	N	Ulcers	Y	N
Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N

Please list any serious medical conditions or hospital stays that you have ever had: \_\_\_\_\_

**Are you allergic to any of the following?**

Aspirin	Y	N	Erythromycin	Y	N	Latex	Y	N
Codeine	Y	N	Jewelry	Y	N	Penicillin	Y	N
Dental Anesthetics	Y	N	Metals	Y	N	Tetracycline	Y	N

Please list any other drugs or materials that you are allergic to: \_\_\_\_\_

I understand that all 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 that it is my responsibility to inform this office of any changes in my medical or dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY    OFFICE USE ONLY**

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

\_\_\_\_\_  
Signature of Dentist

\_\_\_\_\_  
Date

Dentist's Comments: \_\_\_\_\_

Has there been any change in your health status since your last visit?  Y  N

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date

Has there been any change in your health status since your last visit?  Y  N

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date