James E. Martinez, D.D.S., Inc..
Specialist in Orthodontics
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www.cypressbraces.com

Diplomate of the American Board of Orthodontics
Member of the American Association of Orthodontists, Southwestern Society of Orthodontists, & World Federation of Orthodontists

Date: _____

PATIENT INFORMATION (Adult)

Patient's Name: _____ SSN_____

Age: _____ Birth date: _____ Sex: _____ Marital Status:_____

If married, spouses name: _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone:_____

Patient's employer: _____Work phone:_____ Years: ____

Spouse's employer: _____ Work phone: _____ Years: ____

Special interest of the patient: _____

Chief concern regarding the patient's teeth: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____ SSN_____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____Work Phone: _____

Is patient covered by insurance for orthodontic treatment? YES NO - If yes, please fill out the following:

Insurance co. name_____ Insured's name_____

Insurance co. address_____ Relationship to patient_____

Insurance co. phone_____ Insured's birthday_____

Group #_____ Insured's employer_____

Insured's ID# or SS#_____

PERSON TO BE CONTACTED IF PATIENT / PARENT CANNOT BE REACHED

Name: _____ Relation: _____

Address: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

MISCELLANEOUS

Family Dentist: _____

Family Physician: _____

Whom may we thank for referring you to our office? _____

I hereby certify that all information on this form is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in medical status. I also understand that all information on this form is held in the strictest confidence.

Signature: _____ Date: _____

Patient Name_____ **Date**_____

PATIENT MEDICAL HISTORY (Adult)

Is patient in good health? ..... Yes No
Does patient have any history of major illness? ..... Yes No
Has patient ever been under the care
of a physician for illness?..... Yes No
Please explain any pertinent medical history
_____
_____
_____

Does patient wear contact lenses? ..... Yes No
Does patient gag easily? ..... Yes No

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED

Please indicate with (Y) Yes or (N) No

Y	N		Y	N		Y	N		Y	N	
__	__	Heart problems	__	__	Glaucoma	__	__	Hepatitis or Liver problems	__	__	Sinus Problems
__	__	High blood pressure	__	__	Pneumonia	__	__	Kidney Problems	__	__	Stroke
__	__	Low blood pressure	__	__	Tuberculosis	__	__	Measles	__	__	Typhoid Fever
__	__	Circulatory problems	__	__	Epilepsy	__	__	Mumps	__	__	Tonsillitis
__	__	Nervous disorders	__	__	Arthritis	__	__	Psychiatric Care	__	__	Endocrine problems
__	__	Radiation Treatments	__	__	Asthma	__	__	Rheumatic Fever	__	__	Ulcers
__	__	Excessive Bleeding or Anemia	__	__	Diabetes	__	__	Scarlet Fever	__	__	HIV / AIDS
						__	__	Malignancies	__	__	Other _____

__ __ Currently pregnant? If yes, how many months? _____

List any allergies: _____

What medications are now being taken? Please give reasons:_____
_____
_____

Does patient have a tendency to colds? Yes_____ No_____ Sore throats? Yes_____ No_____ Ear infections? Yes_____ No_____

Have tonsils and adenoids been removed? Yes_____ No_____ What age? _____

Date of last physical exam? _____

PATIENT DENTAL HISTORY

Date of last dental exam? _____ Last dental cleaning? _____ Yes No

Have there ever been any injuries to the face, mouth or teeth? ……		_____	_____
Has patient ever sucked fingers or thumb? Until what age?……		_____	_____
Does patient have any speech problems? ……		_____	_____
Does patient grind teeth?	While awake……..……	_____	_____
	While asleep……	_____	_____
Is patient a mouth breather?	While awake……..……	_____	_____
	While asleep……	_____	_____
Has patient been informed of any missing or extra permanent teeth? ……		_____	_____
Has patient consulted an orthodontist previously? ……..……		_____	_____
Did either parent have orthodontic treatment?		_____	_____
Does patient have pain in the jaw joints? ……..……		_____	_____
Right_____ Left_____			
Does patient have popping or cracking of the jaw joints? ……		_____	_____
Right_____ Left_____			

When did this begin? _____
Does patient have headaches? _____ Frequency_____ Location _____

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Signature: _____ Date: _____