Welcome to our office!

CHRISTOPHER J. OVIEDO, DDS MS

Board-Certified Orthodontist

Patient's Information

Name _____ Date _____
First Middle Last

Date of Birth _____ Age _____ Sex ____ Whom may we thank for referring you?_____

Responsible Party Information

Name _____ Relationship to patient_____
First Middle Last

Address _____
Street City State Zip Code

Home Phone # _____ Social Security # _____ Driver's License # _____

Employer _____ Occupation_____ Work Phone #_____

Spouse's Name _____ Relationship to patient_____
First Middle Last

Social Security # _____ Driver's License # _____

Employer _____ Occupation_____ Work Phone #_____

Dental Insurance Information

Insured's Name _____ Relationship to patient_____
First Middle Last

Insured's Social Security # _____ Insured's Date of Birth _____

Insurance Company _____ Group # _____ Local #_____

Insurance Co. Address _____ Phone #_____

Insured's Employer _____ Employer's Address _____

Emergency Information

Name of nearest friend or relative NOT living with you _____

Address _____ Phone# _____

(Please continue on back)

Patient's Medical History

Physician's Name_____ Last Medical Exam _____ Medical Card #_____

Address _____ Phone_____

What medications are you taking now?_____ For what purpose? _____

Are you allergic to ☐Penicillin ☐Codeine ☐Local anesthetic injections ☐Other_____

Is your general health good? ☐Yes ☐No Reason _____

Any major or unusual illnesses? ☐No ☐Yes Explain_____

Are you being treated by a physician now: ☐No ☐Yes For what?_____

Have you ever been diagnosed or treated for any of the following (check all that apply)?

☐ Heart disease	☐ Hepatitis or liver problems	☐ A.I.D.S.
☐ Congenital heart defect	☐ Jaundice	☐ H.I.V. positive
☐ Rheumatic fever	☐ Stomach problems/ulcers	☐ Venereal disease
☐ Heart murmur	☐ Diabetes	☐ Herpes
☐ Bleeding problems	☐ Epilepsy	☐ Asthma/breathing problems
☐ Anemia	☐ Cancer or leukemia	☐ Tuberculosis or lung disease
☐ Abnormal blood pressure	☐ Frequent headaches	☐ Sinus trouble or hay fever

If yes, please explain _____

Do you now, or in the past, have/had any other diseases or medical problems NOT in the list above? ☐No ☐Yes

If yes, please explain _____

Female patients: Are you pregnant or possibly pregnant? ☐No ☐Yes If yes, how far along? _____

Dental History

Reason for this visit? _____ General dentist_____

Date of last visit_____ Last X-rays _____ Do you have any dental pain at this time?_____

Have you had, or do you notice any of the following (check all that apply)?

☐ Teeth sensitive to hot, cold, sweets, or pressure	☐ Clenching or grinding of teeth ☐ day ☐ night
☐ Traumatic injury to teeth, mouth, or face	☐ Loosening of your teeth
☐ Pain or tenderness around ear, joint, or side of face	☐ Periodontal treatment
☐ Difficulty in ☐ opening ☐ closing ☐ chewing	☐ Mouth breathing
☐ Clicking, locking, or popping of jaw joint	☐ Missing teeth
☐ Tonsils or adenoids removed	☐ Additional teeth
☐ Oral habits ☐ thumb sucking ☐ fingernail biting	☐ cheek biting
☐ Pain and/or swelling of gums, bleeding of gums when brushing	

If yes, explain _____

What do you feel is wrong with your teeth or bite? _____

Have you had orthodontic treatment? ☐No ☐Yes When? _____ Orthodontic consultations? ☐No ☐Yes When?_____

Has any member of your family had orthodontic treatment? ☐No ☐Yes Who? _____

Is there anything else we should know? _____

I understand that credit bureau reports may be obtained. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I read and understand English.

Signature of Patient _____ **Date**_____