Los Feliz Orthodontics
Merilynn Yamada DDS

1655 Hillhurst Ave Suite 203, Los Angeles, CA 90027
p: (323) 663-4610 | e: Smile@LosFelizOrthodontics.com
losfelizorthodontics.com

Adult Patient Information

Please fill out this form and bring to your first appointment.
Thank you for choosing us for your orthodontic care!

Patient First Name _____ **Middle** _____ **Last** _____

Today's Date:____/____/____ I prefer to be called _____ ☐ Male ☐ Female Birthdate: ____/____/_____ Age:_____

Address: _____ Apt. # _____ City_____ State_____ Zip_____

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Main phone to call_____ Ext._____
Home Cell Other non-work number

Email: _____ Best way to reach me: □ Phone □ Email □ Text □ All □ Other_____

Who may we thank for referring you to our office? (List all names if more than one)_____

What is your main concern in seeking an orthodontic consultation?_____

Dentist:_____ City_____ Phone_____ Yrs with DDS _____ Date of last visit_____

Physician:_____ City_____ Phone_____ Needs:_____

Other Medical or Dental Specialists seen? _____ Hobbies/Interests_____

Occupation: _____ Employed by: _____ Work Phone: (_____) _____ - _____

Work Address:_____ Suite_____ City_____ State_____ Zip_____

Marital Status: □ Single □ Divorced □Married Spouse First Name:_____ Middle_____ Last_____

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Email: _____
Home Cell Other

Occupation: _____ Employed by: _____ Work Phone: (_____) _____ - _____

Work Address: _____ I give my permission to discuss my treatment with my spouse _____initial

INSURANCE: Fill out all information and bring your insurance card.

Dental Insurance? □ No □Yes Provider: _____ Benefit: _____ Group #: _____ Subscriber #: _____

Orthodontic Coverage? □No □Yes Maximum: $_____ Any benefits used to date?_____

Other Dental Insurance? □ No □Yes Benefit_____ Other Orthodontic Insurance? □ No □Yes Benefit_____

Insured's name_____ Relation to you_____ Provider: _____ Group #: _____ Subscriber #: _____

Medical Insurance:_____ Flex plan? □ No □Yes Describe_____

FINANCIAL RESPONSIBILITY ☐ Patient (□ See info above) ☐ Spouse (□ See info above) ☐ Other (List information below)

Name: _____ Relationship to you: _____ Email_____

Address: (□ Same as patient) _____ City _____ State_____ Zip _____

Phone: Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____ Best #/Time_____

Birthdate: ____/____/_____ SSN: _____ - ____ - _____ Driver's License #: _____ State_____

Occupation: _____ Employed by: _____ Work Phone: (_____) _____ - _____

ADDITIONAL EMERGENCY CONTACT: Name_____ Relation to you_____

Address: _____ City_____ State_____ Zip_____

Phone: (____) _____ - _____ (____) _____ - _____ (____) _____ - _____ Email: _____
Home Cell Phone Work

Last Revised: 06/13/2010

Patient Name:_____ **Date**_____ Staff member reviewing:_____

ADULT MEDICAL & DENTAL HISTORY Please answer the following questions with Yes or No to indicate if you currently have or have a history of any of the conditions listed. If you checked Yes, check appropriate boxes that apply and explain if necessary. Let us know if you have questions or need extra pages. Thank you.

Current MEDICAL treatment or needs? ☐ No ☐ Yes

Good health, appetite, energy level? ☐ No ☐ Yes
Explain if no:

Medications/drugs being taken now: ☐ No ☐ Yes

Need premedication for dental procedures? List ☐ No ☐ Yes
- ☐ Antibiotics for heart murmur/valve
- ☐ Antibiotics for joint replacements
- ☐ Blood clotting aids ☐ Other

Surgeries or hospitalizations? ☐ No ☐ Yes
- ☐ prior
- ☐ needed

Problems with the Immune System? ☐ No ☐ Yes
- ☐ Frequent infections
- ☐ AIDS ☐ HIV+
- ☐ Other

Liver problems? ☐ No ☐ Yes

Hepatitis? ☐ No ☐ Yes

Kidney problems? ☐ No ☐ Yes

Genito-urinary problems? ☐ No ☐ Yes
- ☐ Sexually transmitted diseases
- ☐ Other

Illnesses, Diseases? ☐ No ☐ Yes
- ☐ Cancer ☐ Treatment for cancer
- ☐ Tuberculosis ☐ Polio
- ☐ Rheumatic/Scarlet Fever
- ☐ Other

Endocrine or Hormonal problems? ☐ No ☐ Yes
- ☐ Hyperthyroid ☐ Hypothyroid
- ☐ Other

Injuries? ☐ No ☐ Yes
- ☐ Car accident ☐ Whiplash
- ☐ Other

Drug reactions? ☐ No ☐ Yes
- ☐ penicillin ☐ other antibiotics
- ☐ codeine ☐ aspirin
- ☐ ibuprofen (Advil, Motrin)
- ☐ Local anesthesia (novacaine, etc.)

Substance abuse problems? ☐ No ☐ Yes

Allergies (check all that apply)? ☐ No ☐ Yes
- ☐ latex ☐ metals
- ☐ acrylics ☐ seasonal
- ☐ milk ☐ other foods
- ☐ other

Heart Circulation Problems? ☐ No ☐ Yes
- ☐ Heart murmur/Valve problem
- ☐ Blood Pressure ☐ High ☐ Low
- ☐ Stroke ☐ Angina or chest pains
- ☐ Heart attack ☐ Heart surgery
- ☐ Need to take medication regularly
- ☐ Other

Bleeding Problems? ☐ No ☐ Yes
- ☐ Hemophilia ☐ Bruise easily
- ☐ Bleed easily/excessively ☐ Anemia
- ☐ Other

Blood Sugar problems? ☐ No ☐ Yes
- ☐ Low blood sugar/hypoglycemic
- ☐ High blood sugar/hyperglycemic
- ☐ Diabetic ☐ Needs medication
- ☐ Other

Lungs/Breathing problems? ☐ No ☐ Yes
- ☐ Asthma ☐ Wheezing
- ☐ Shortness of breath
- ☐ Enlarged tonsils and adenoids ☐ removed
- ☐ Other

Digestive System Problems? ☐ No ☐ Yes
- ☐ Appendix removed ☐ Ulcers
- ☐ Other

Bone/Joint/Muscle Problems? ☐ No ☐ Yes
- ☐ History broken bone(s)
- ☐ Osteoporosis ☐ Joint Pain
- ☐ Arthritis ☐ Rheumatoid
- ☐ Fibromyalgia ☐ Other:

Sensory/Motor Problems? ☐ No ☐ Yes
- ☐ Vision/Hearing/Speech
- ☐ Other

Neurological? ☐ No ☐ Yes
- ☐ Fainting ☐ Dizziness
- ☐ Epilepsy ☐ Convulsions
- ☐ ADD/ADHD ☐ Other

Pain? ☐ No ☐ Yes
- ☐ Face ☐ Body ☐ Back ☐ Jaw
- ☐ Other

Psychological? ☐ No ☐ Yes
- ☐ Frequent anxiety ☐ Insomnia
- ☐ Depression ☐ Neurosis
- ☐ Psychiatric disorder
- ☐ Other

Nose/Sinus ☐ No ☐ Yes
- ☐ Frequent congestion
- ☐ Mouth breather
- ☐ Frequent sinus problems
- ☐ Other

Females: Are you pregnant or plan to become pregnant during the course of your orthodontic treatment? ☐ No ☐ Yes

Names and ages of children?

CURRENT DENTAL needs? ☐ No ☐ Yes

History of injury to teeth? ☐ No ☐ Yes

Oral diseases? ☐ No ☐ Yes
- ☐ Oral or lip sores ☐ Herpes
- ☐ Other

Problem teeth? ☐ No ☐ Yes

Sensitive teeth? ☐ No ☐ Yes

Missing or extra teeth? ☐ No ☐ Yes

Habits List or check below
- Do you smoke? ☐ No ☐ Yes
- Finger, thumb, or lip habit? ☐ No ☐ Yes
- Bites: ☐Nails ☐Objects ☐ No ☐ Yes
- Bite objects i.e., pens? ☐ No ☐ Yes
- Chew: ☐ ice ☐ gum ☐ No ☐ Yes

Gum or periodontal problems? ☐ No ☐ Yes

Seeing specialists? ☐ No ☐ Yes

Jaw or TMJ problems? ☐ No ☐ Yes
- Jaw click, pop or grating sound? ☐ No ☐ Yes
- Jaw soreness, pain or stiffness? ☐ No ☐ Yes
- Jaw locking or getting "stuck"? ☐ No ☐ Yes
- Jaws sore or stiff in morning? ☐ No ☐ Yes
- Face/muscle aches? ☐ No ☐ Yes
- History of trauma to face, jaws, teeth? ☐ No ☐ Yes
- Headaches? ☐ mild moderate Migraines ☐ No ☐ Yes
- Previous jaw treatments? ☐ No ☐ Yes
  - ☐ occlusal or nightguard
  - ☐ therapy ☐ medications

Oral or Jaw surgery? ☐ No ☐ Yes

Teeth removed

Previous Orthodontic Consultation? ☐ No ☐ Yes

Findings:

Previous Orthodontic Treatment? ☐ No ☐ Yes

Year

Functional problems:
- Tongue thrust? ☐ No ☐ Yes
- Grinding/clenching teeth? ☐ No ☐ Yes
  - ☐ Day ☐ Night ☐ Severe
- Snoring? ☐ loud ☐ mild ☐ No ☐ Yes
- Noisy breathing when sleeping? ☐ No ☐ Yes
- Stopping breathing during sleep? ☐ No ☐ Yes
- Difficulty breathing through nose? ☐ No ☐ Yes
- Excess tiredness after 8 hrs sleep? ☐ No ☐ Yes
- Acid reflux problems? ☐ No ☐ Yes
- Ever fallen asleep while driving? ☐ No ☐ Yes

Have you taken intravenous bisphosphonates such as Zometa , Aredia, or Didronel for bone disorders or cancer? ☐ No ☐ Yes

Have you taken oral bisphosphonates such as Fosamax, Actonel, Boniva, Skelid or Didronel for bone disorders or cancer? ☐ No ☐ Yes

FAMILY MEDICAL HISTORY Have your parents or siblings ever had any of the following:

☐ Bleeding disorder ☐ Arthritis ☐ Jaw pain or noises ☐ Periodontal disease ☐ Orthodontic extractions (not wisdom) ☐ Sleep Apnea
☐ Diabetes ☐ Severe allergies ☐ Jaw size imbalance ☐ Orthodontic treatment ☐ Problems with dental treatment ☐ Other

Describe:

Are there any omissions in the medical or dental history? Please list below and/or provide clarification to any of the above questions. ☐ No ☐ Yes

Realizing that successful treatment greatly depends upon complete cooperation following instructions, keeping appointments, maintaining oral hygiene and regular visits to your dentist, are there any restrictions, handicaps, or problems that might be encountered during treatment? ☐ No ☐ Yes

Describe:

I have read and understand the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in completion of this form. I will notify my orthodontist in writing of any changes in my medical or dental health status.

Patient's Signature *Date* *Doctor's Signature* *Date*

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