ORTHO WORKS®
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DAVID SHEN, D.M.D. & ASSOCIATES
SPECIALISTS IN ORTHODONTICS & INVISALIGN®

ADULT PATIENT INFORMATION

PATIENT INFORMATION (Please Print)

Patient's Name _____ (Last / First / Middle) Date of Birth _____ (Month / Day / Year) M___ F___

Home Address _____ (Street / City / Zip Code) Phone ( ) _____

Social Security Number _____ E-mail Address _____

Employer _____ Occupation _____

Work Address _____ (Street / City / Zip Code) Phone ( ) _____

Referred By _____

Dentist _____ Phone ( ) _____

Physician _____ Phone ( ) _____

Spouse's Name _____ (Last / First / Middle) Date of Birth _____

Social Security Number _____

Employer _____ Occupation _____

Spouse's Work Address _____ Phone ( ) _____

Are you covered by orthodontic insurance? ☐ **Yes** ☐ **No**
If yes, please complete the following information.
IF YOU HAVE COVERAGE FROM MORE THAN ONE COMPANY, PLEASE GIVE ALL INFORMATION FOR EACH COMPANY.

Name of Insurance Company | Name of Policy Holder | Date of Birth

Policy Holders' Employer(s) | Union Local Number(s) | Employer Group Number

Person Responsible for Account _____
(If person other than above, please give address, phone and relationship.)

DENTAL HISTORY

Date of last dental care _____

Family history of orthodontic problems _____

Were there any habits which might have caused the teeth to move? (i.e. nail or lip biting, thumb sucking, etc.) _____

Has an orthodontist been consulted previously? _____

Have you ever had your teeth straightened? (orthodontic) ☐ Yes ☐ No If yes, when _____

What is your main concern? _____

GUM	**Yes**	**No**
Have you ever had treatments for gum disease?	☐	☐
If yes, when and by whom: _____		
Do your gums bleed?	☐	☐
Have you had any gum boils or swelling?	☐	☐
TEETH	**Yes**	**No**
Are you self-conscious about the appearance of your teeth?	☐	☐
Do your teeth feel loose?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have sore or sensitive teeth?	☐	☐
a) To cold, hot or sweet	☐	☐
b) Chewing pressure	☐	☐
Has there been any injury to the face, mouth or teeth?	☐	☐
TMJ	**Yes**	**No**
Does your jaw click, hurt or lock?	☐	☐
Do you have pain elsewhere in your face or jaw?	☐	☐

ORAL HYGIENE	**Yes**	**No**
Has a dentist or hygienist shown you how to clean your teeth?	☐	☐
Do you still use these methods?	☐	☐

How often do you brush your teeth? _____

List type of toothbrush: ☐ hard ☐ medium ☐ soft ☐ electric ☐ other _____

List any other aids: ☐ floss ☐ Stimudent ☐ water spray device ☐ rubber tip ☐ toothpick ☐ other _____

How often used: _____

When was your last professional dental cleaning? _____

How often scheduled? _____

Additional general dental information: _____

MEDICAL HISTORY

Date of last medical care _____

Have you been a patient in a hospital in the past 2 years? ☐ Yes ☐ No Reason: _____

Health is ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do any of the following pertain to you? *(Please check and describe fully under remarks.)*

	Yes	No
1. Allergies	☐	☐
a) Penicillin or other Antibiotics	☐	☐
b) Local anesthetic	☐	☐
c) Metal	☐	☐
d) Latex	☐	☐
e) Other	☐	☐
2. Arthritis	☐	☐
3. Asthma	☐	☐
4. Blood Disease or Abnormal Bleeding Problems	☐	☐
a) Anemia	☐	☐
b) Clotting problems	☐	☐
c) Excessive bleeding requiring treatment	☐	☐
d) Other blood disorders	☐	☐
5. Chest Pains, Ankle Swelling or Shortness of Breath	☐	☐
6. Diabetes	☐	☐
Occurrence in immediate family	☐	☐
7. Epilepsy	☐	☐
8. Fainting	☐	☐
9. Glandular Disease (thyroid, etc.)	☐	☐
10. Glaucoma	☐	☐
11. Heart Disease	☐	☐
12. Heart Murmur	☐	☐

	Yes	No
13. Rheumatic Fever	☐	☐
14. Stroke	☐	☐
15. Do you have a pacemaker?	☐	☐
16. High Blood Pressure	☐	☐
17. Low Blood Pressure	☐	☐
18. Kidney Disease	☐	☐
19. Liver Disease, Hepatitis, Jaundice	☐	☐
20. Psychiatric Treatment	☐	☐
21 Radiation Treatment	☐	☐
22. Respiratory Disease	☐	☐
23. Stomach or Duodenal Ulcers	☐	☐
24. Tumor History	☐	☐
25. Venereal Disease	☐	☐
26. Are you pregnant?	☐	☐
27. A.I.D.S. / HIV +	☐	☐
28. Phen-Fen or Diet Drugs	☐	☐
29. Bisphosphonates	☐	☐
30. Other medical concerns: _____		

	Yes	No
31. Are you taking medicine, drugs or pills regularly?	☐	☐
If so, name of medication(s) _____		
32. Do you require pre-medication with antibiotics prior to dental treatments (based on physicians instructions)?	☐	☐
If so, name of medication(s) _____		
33. Have you experienced any unfavorable reaction to previous dental treatments?	☐	☐

Please explain particulars regarding any "yes" answers given above: _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor or his nurse or qualified designate.

I also acknowledge full responsibility for the payment of such services and agree to pay for them. OrthoWorks Dental Group may run a credit report on me and/or my guarantor.

I authorize assignment of insurance benefits payable to OrthoWorks.

Signed _____ Date _____
Patient, Parent or Agent (Must be 18 years or older)

There is no change, to my personal knowledge, on my medical history. Medical History Reviewed:

Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____