



Central Austin
1814 W. 35th Street
Austin, TX 78703
(512) 451-6457
fax 451-6461

www.bracesaustin.com

Steiner Ranch Orthodontics
4302 N Quinlan Park Rd.
Austin, TX 78732
(512) 266-8585

Bastrop
708 Pecan
Bastrop, TX 78602
(512) 303-1060



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ABOUT YOU

Today's Date: 01-21-2012 E-Mail Address: ashwini.patola@gmail.com

Name: patola pp, ashwini srija reddy

LAST FIRST MI MR MRS MS DR

I prefer to be called: ashwini ☐ Male ☒ Female

Birthdate: Age: SS #:

Home Address: jkkj

APT/CONDO #:

CITY

STATE

ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (676) 776-7767 Pager / Other #:

Wk #: Ext: DL #:

Employer:

Employer's Address:

How long there? Occupation:

Where & when are best times to reach you? cell: eve

Whom may we Thank for referring you?

Other family members seen by us: none

General Dentist: hju

Last Visit Date:

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SPOUSE INFORMATION

His / Her Name:

Employer:

Wk #: Ext: SS #:

Birthdate:

Person Responsible for Account:

Wk #: Ext: Hm #:

Billing Address:

Relation: SS #:

Employer: DL #:

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ORTHODONTIC INSURANCE

Primary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #: ()

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthdate: Insured's SS #:

Insured's Employer:

Secondary

Orthodontic Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #: ()

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthdate: Insured's SS #:

Insured's Employer:

In the event of an emergency, is there someone
who lives near you that we should contact?

His / Her Name: Relation:

Wk #: Hm #:

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MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:

Phone #: Date of last visit:

CONTINUED ON BACK

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MEDICAL HISTORY *continued*

Your current physical health is:

☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician?

☐ Yes ☐ No

Please explain: _____

Are you taking any prescription / over-the-counter drugs?

☐ Yes ☐ No

Please list each one: _____

For Women: Are you taking birth control pills?

☐ Yes ☐ No

 Are you pregnant? ☐ Yes ☐ No

Week #: _____

 Are you nursing? ☐ Yes ☐ No

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

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N High / Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma / Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Drug / Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Severe / Frequent Headaches |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy / Seizures / Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters / Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers / Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery / Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Any Metals/Plastics | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list any other drugs/materials that you are allergic to: _____

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DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever had or been evaluated for orthodontic treatment?

☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work?

☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?
☐ Yes ☐ No

Your current dental health is:

☐ Good ☐ Fair ☐ Poor

Do you like your smile?

☐ Yes ☐ No

Gums ever bleed?

☐ Yes ☐ No

Have you ever had an injury to your:

☐ Mouth ☐ Teeth ☐ Chin (Check all that apply)

Do you have any speech problems?

☐ Yes ☐ No

Do you generally breathe through your mouth?

 If yes, please check: ☐ While Awake? ☐ While Asleep?

Do you have any missing or extra permanent teeth?

☐ Yes ☐ No

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin)

☐ Yes ☐ No

If yes, when? _____

Do you smoke or use tobacco in any form?

☐ Yes ☐ No


I understand that 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 it is my responsibility to inform this office of any changes in my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

Signature _____

Date _____

Thank you for filling out this form completely.

This office reserves the right to verify the 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.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature _____

Date _____

Signature _____

Date _____

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

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____
