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Austin, TX 78732
(512) 266-8585

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Bastrop, TX 78602
(512) 303-1060



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ABOUT YOU

Today's Date: _____ E-Mail Address: ashwini.patola@gmail.com

Name: patola, ashwini reddy MS
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☒ Female

Birthdate: _____ Age: _____ SS #: _____

Home Address: _____
APT/CONDO #:

CITY STATE ZIP
☐ Single ☒ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____) _____ Pager / Other #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

General Dentist: _____

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

Do you generally breathe through your mouth? ☐ Yes ☒ No

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: _____

