Steiner Ranch Orthodontics
4302 North Quinlan Park Rd.
Austin, TX 78732
(512) 266-8585
fax 266-8580
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Central Austin
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Austin, TX 78703
(512) 451-6457

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

ADA | Diplomate American Board of Orthodontics | Member American Association of Orthodontists

1 About You

Today's Date: _____ E-Mail Address: _____

Name: kk ashwini
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☑ Female

Birthdate: 2011-11-15 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: _____

2 Spouse Information

His / Her Name: praneeth

Employer: _____

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

Birthdate: _____

Person Responsible for Account: _____

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

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 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: 2011-11-15 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: 2011-11-15 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 #: (____) _____

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: 2011-11-15

CONTINUED ON BACK

4 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?

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

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

nothing serious

Are you allergic to any of the following?

☐ Y ☐ N Aspirin	☐ Y ☐ N Dental Anesthetics	☐ Y ☐ N Penicillin
☐ Y ☐ N Any Metals/Plastics	☐ Y ☐ N Erythromycin	☐ Y ☐ N Tetracycline
☐ Y ☐ N Codeine	☐ Y ☐ N Latex	☐ Y ☐ N Other

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

5 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?

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

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.

Signature _____ Date _____

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 _____

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: _____