JAMES WATERS ORTHODONTIST

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

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1 About You

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

Name: paltola, ashwini
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: 1986-06-11 Age: 24 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: 2011-09-18

2 Spouse Information

His / Her Name: _____

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: cue

Insured's Birthdate: 1966-07-10 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: 2

Insured's Birthdate: 1957-10-16 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: emerfirst last Relation: ckie

Wk #: (____) _____ Hm #: (543) 782-9878

4 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: 2007-08-08

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:

none

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: _____