JAMES WATERS ORTHODONTIST

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Bastrop, TX 78602
(512) 303-1060

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1 About You

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

Name: patlola, 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: _____

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: _____

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 #: (____) _____

4 Medical History

Do you have a personal physician? ☑ Yes ☐ No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

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:

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? 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.

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: _____