Welcome

PASHA ORTHODONTICS, LLC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you to help achieve your ideal smile.

1. Patient Information

DATE _____

Name _____
Last Name First Name Middle Initial

Preferred Name _____

D.O.B. _____/_____/_____ Sex ❑ Male ❑ Female

Home Phone (_____)_____ Cell Phone (_____)_____

Address _____ Ste./Apt.#_____

_____
City State Zip

Email_____Occupation_____

Patient Employer/School_____

Employer/School Address_____

In case of an emergency, who should we notify?

_____

Relationship to patient_____ Phone No.(___)_____

How did you hear about our office/whom may we thank for referring you?

_____

2. Person Responsible for Account

Name _____
Last Name First Name Middle Initial

Relationship to patient_____

❑ Married ❑ Widowed ❑ Single

❑ Separated ❑ Divorced ❑ Partnered for ____yrs.

Address _____ Ste./Apt.#_____

_____
CITY STATE ZIP

Home Phone (_____)_____ Cell Phone (_____)_____

Employer_____

Employer Address_____

DL # _____SS#_____

Additional person authorized on account ❑ Yes ❑ No

Name _____
Last Name First Name Middle Initial

Relationship to patient_____

Authorized access to	Account info/billing	❑ yes	❑ no
	Treatment updates	❑ yes	❑ no
	Make appointments	❑ yes	❑ no

3. Primary Dental Insurance

Orthodontic Coverage? ❑ YES ❑ NO

Insurance Co. Name _____

ID or Social Security#_____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #) _____

Policy Holder Name_____

Relationship to Patient_____

Policy Holder Birthdate_____/____/____

4. Secondary Dental Insurance

Orthodontic Coverage? ❑ YES ❑ NO

Insurance Co. Name _____

ID or Social Security#_____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local or Policy #) _____

Policy Holder Name_____

Relationship to Patient_____

Policy Holder Birthdate_____/____/____

5. Tell us about yourself

Hobbies _____

Favorite Color_____

Nickname_____

Musical instruments played_____

Have we treated any other family member? ❑ Y ❑ N

If yes, names _____

Tushar Shah D.D.S.
Pranav Patel D.D.S.
Bruce Wardell D.M.D.
www.pashaorthodontics.com

Please Complete Both Sides

PASHA ORTHODONTICS, LLC

6. Patient Dental History

Have you ever been evaluated or had orthodontic treatment before? ❑ YES ❑ NO

If yes, by whom?_____When?_____

General Dentist_____

Dentist Phone (____)_____Date of Last Visit___/___/___

How often do you brush?_____How often do you floss?_____

Your dental health is ❑ Good ❑ Fair ❑ Poor

Please check if you have or have had any of the following

- ❑ Bleeding gums, bad taste or mouth odor
- ❑ Clenching/Grinding Teeth
- ❑ Frequent oral habits (lip/finger/thumb sucking, nail biting, etc.)
  If yes, please explain_____
- ❑ Food impaction between the teeth
- ❑ History of speech problems or speech therapy
- ❑ Informed of any missing or extra permanent teeth
- ❑ Injuries to the face, mouth, teeth or chin
  If yes, please explain_____
- ❑ Mouth breathing habit
- ❑ Pain/tenderness or clicking/locking of your jaw joints (TMJ/TMD)
- ❑ Snoring
- ❑ Teeth sensitivity
- ❑ Tongue Thrust (abnormal swallowing)
- ❑ Other dental related issues_____

7. Patient Medical History

Are you currently under the care of a physician? ❑ Yes ❑ No

If yes, physicians name _____

Are you pregnant? ❑ Yes ❑ No

Please check if you have or have had any of the following

- ❑ ADD/ ADHD
- ❑ Adenoids or tonsils removed
- ❑ Anemia/Abnormal bleeding
- ❑ Artificial bones/joints /valves
  _____
- ❑ Asthma
- ❑ Birth defects or hereditary problems _____
- ❑ Blood transfusion
- ❑ Cancer
- ❑ Diabetes or low blood sugar
- ❑ Fainting
- ❑ Frequent headaches or migraines
- ❑ Frequent ear infections/ colds/throat infections
- ❑ Hepatitis
- ❑ HIV+ / AIDS
- ❑ Handicaps/Disabilities
- ❑ Heart murmur or heart problems
- ❑ Kidney/ Liver problems
- ❑ Mental health disturbance/ depression
- ❑ Seizures /Epilepsy
- ❑ Serious illness or operations
  _____
- ❑ Sinus problems/ difficulty breathing through nose
- ❑ Tuberculosis (TB)
- ❑ Vision, hearing or speech problems
- ❑ Any other medical concerns / conditions
  _____

Please list any medications/ prescriptions that you are currently taking

_____

_____

ALLERGIES

_____

_____

8. Authorization

All remaining payments are due in full prior to debanding date unless prior arrangements have been approved.

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. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

SIGNATURE DATE

Policy Agreement

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____

SIGNATURE DATE

Medical History update or changes for returning patients.

Have there been any changes in your health status since your last visit?

❑ YES ❑ NO

If Yes, Please explain _____

_____

_____

_____

SIGNATURE DATE

OFFICE USE ONLY

Medical/dental information above has been renewed and entered in system file.

_____ _____

Staff initials Date