Petaluma Orthodontics

Dr. John S. Woo
Dr. Marc DeBerardinis

Patient's Name: Last _____ First _____ Middle _____
Sex: M ☐ F ☐ Birthdate: _____ Age: _____ (For Children) Patient lives with: Mom ☐ Dad ☐ Both ☐
Marital Status of parents: Single ☐ Married ☐ Divorced ☐ Remarried ☐ Other ☐
Whom may we thank for referring you to our office? _____ Patient's Dentist: _____

Responsible Party Information

Name: Last _____ First _____ Middle _____
Address: _____ City _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer Occupation

Responsible Party's Spouse

Name: Last _____ First _____ Middle _____
Address: _____
Home Phone _____ Cell Phone _____
Employer _____ Occupation _____
Relationship to Patient: _____

Dental Insurance Information

Insurance Carrier's Name _____ Group# _____
Subscriber's Full Name: _____
Subscriber's ID# _____
Subscriber's Date of Birth: _____
Subscriber's Employer _____

Medical History

Yes	No		Yes	No		Yes	No	
☐	☐	Fainting/Dizziness	☐	☐	Bone disorder	☐	☐	Neurological Disorders
☐	☐	Blood Pressure	☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Heart Trouble	☐	☐	Epilepsy	☐	☐	Liver (Hepatitus)
☐	☐	Prolonged bleeding	☐	☐	Thyroid	☐	☐	Positive HIV Virus (AIDS)
☐	☐	Rheumatic Fever	☐	☐	Kidneys	☐	☐	Arthritis of any kind

Is there any other medical problem (or history of) that we should be aware of? _____
List any drug allergies or drug sensitivities _____
List any drug/medications now being taken _____
Are you allergic or sensitive to latex? _____

Dental History

Have there been any injuries to the teeth, mouth or jaws? _____
Thumb of finger sucking? Until what age? _____
Are any teeth especially sensitive? _____
Do the jaw joints make noise (clicking, popping or grating sounds?) _____
Is there pain in front of, behind, or in your ears? _____
Is there difficulty when chewing or opening wide? _____
Is there tension or spasms in the head or neck? _____
Is stress or nervous tension affecting this problem? _____
Are there headaches in the morning, noon or evening? _____
Have you had a previous orthodontic examination? _____
Last dental visit? _____ Were X-rays taken? _____
What are the primary concerns? _____

I authorize Dr. John S. Woo andDr. Marc deBerardinis to release any information, including diagnosis, records of treatment,examination rendered to my child or me during this period of such dental care to third party payors and/or other health practitioners.I give release for the office to use my photographs and the first intial or name of my child or self for office bulletin displays and/or office websites. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.

Signature _____ Date _____