Petaluma Orthodontics

Dr. John S. Woo
Dr. Marc DeBerardinis

Patient's Name: Last ____ First ____ Middle ____
What is your appointment reminder preference? Email ☐ Phone ☐
Sex: M ☐ F ☐ Birthdate: ____ Age: ____ (For Children) Patient lives with: Mom ☐ Dad ☐ Both ☐
Please list your sports and hobbies:
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 jointsmake noise (clicking, popping or grating sounds?) ____
Is there pain in front of, behind, or inyour ears? ____
Is there dificulty 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 ____