Mark Y. Iritani, DDS, PC

Welcome!

Patient Information

Date_____/_____/_____ **Sex_____** **Age_____**

Patient's Name____
Last First Middle

Address____
Street City State Zip

Home Phone____________ **Birthdate**_____/_____/_____ **Email Address**____________________

Parent's or Guardian's Name____

School________________________________ **Grade**____________________

Patient's Dentist____________________ **Physician**____________________

Names and birthdates of other children in the family____________________

Whom may we thank for referring you to our office?____________________

Do you anticipate a move or transfer in the near future? **Yes_____** **No_____**

Responsible Party Information

Name____
Last First Middle Marital Status

Mailing Address____
Street City State Zip

Cell Phone____________ **Work Phone**____________ **Email Address**____________________

Social Security #_____/___/_______ **Birthdate**_____/_____/_____ **Relationship to Patient**____________________

Employer ____________________ **Occupation**____________________ **No. of Years Employed**_________

Other Parent's Name____
Last First Middle

Cell Phone____________ **Work Phone**____________ **Email Address**____________________

Social Security #_____/___/_______ **Birthdate**_____/_____/_____ **Relationship to Patient**____________________

Employer____________________ **Occupation**____________________ **No. of Years Employed**_________

Insurance Information

Insured's Name________________________________ **Social Security #**_____/___/________

Insurance Company____________________ **Group #**______________ **Phone #**__________________

Do you have double coverage? **Yes_____** **No_____**

Insured's Name________________________________ **Social Security #**_____/___/________

Insurance Company____________________ **Group #**______________ **Phone #**__________________

*** I understand that where appropriate, credit bureau reports may be obtained**

Medical History

Check any of the following for which the patient has been treated

__	Diabetes	__	Anemia	__	Prolonged Bleeding
__	Pneumonia	__	Epilepsy	__	Fainting or Dizziness
__	Heart Trouble	__	Asthma	__	Nervous Disorders
__	Rheumatic Fever	__	Hepatitis	__	Kidney Involvement
__	Bone Disorders	__	Tuberculosis	__	Endocrine Problems

Has the patient had or does have any diseases or major illness we should be aware of? __ Yes __ No
If yes, please describe____

Is the patient in good health? __Yes __No Does the patient have a tendency for: __colds? __sore throats?

Have the tonsils and adenoids been removed? __Yes __No If yes, at what age_____

List any drugs or medications now being taken. Give reasons____________________________________

List any allergies or drug sensitivity____

Date of last visit to the dentist_____________________________ Date of last physical exam_____________________________

Jaw Problems Has the patient ever experienced the following:

- **a. Clicking of the jaw? __Yes __No**
- **b. Pain (in the jaw joint, ear, side of face)? __Yes __No**
- **c. Difficulty in opening and/or closing? __Yes __No**
- **d. Difficulty in chewing? __Yes __No**

Habits Does the patient currently:

- **a. Bite fingernails? __Yes __No**
- **b. Clench or grind teeth while awake or asleep? __Yes __No**
- **c. Hold foreign objects with teeth (i.e. pencils, pens, fingernails)? __Yes __No**

Does the patient have headaches? __Yes __No If yes, frequency_____________________ location______________________

Has there been any injury to the face, mouth or teeth? __Yes __No If yes, when___________________________________

Has the patient ever sucked their thumb or finger(s)? __Yes __No If yes, until what age__________________________

Does the patient have any speech problems? __Yes __No If yes, describe_______________________________________

Is the patient a mouth breather while awake? __Yes __No While asleep? __Yes __No

Has the patient been informed of any missing permanent teeth? __Yes __No Extra permanent teeth? __Yes __No

Has the patient reached puberty? (Girls: menstruation started? Boys: voice changed?) __Yes __No

Has another orthodontist been consulted previously? __Yes __No

Has either parent had orthodontic treatment? Mom: __Yes __No Dad: __Yes __No

List areas of interest, hobbies, musical instruments:____

Orthodontic concerns/reason for consultation:____

Is the patient adopted? __Yes __No If yes, does the patient know? __Yes __No

Are there any learning disabilities? __Yes __No If yes, describe_______________________________________

Parent or Guardian Signature____ Date_____/_____/______

Doctor Signature____ Date_____/_____/______