Orthodontics for Adults & Children

Bobby Shemirani, DDS, MS

Patient Information

Today's Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Preferred Phone_____Birthdate_____ (If minor) Patient lives with ☐Mom ☐Dad ☐Both Parents

If patient is a minor, give parent's or guardian's name _____

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

Parent/Guardian Information **(Please fill in information for BOTH parents/guardians)**

Name_____ E-Mail Address _____

Mailing Address_____

Home Phone_____ Cell Phone_____ Work Phone _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation _____

Name_____ E-Mail Address _____

Mailing Address_____

Home Phone_____ Cell Phone_____ Work Phone _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation _____

Dental Insurance Information

Subscriber's Name_____ Subscriber's Social Security # _____

Insurance Company_____ Group No._____ Insurance ID #_____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Subscriber's Name_____ Subscriber's Social Security # _____

Insurance Company_____ Group No._____ Insurance ID #_____

Insurance Co. Address_____ Phone No. _____

I authorize Dr. Shemirani's office to check benefits and bill my insurance carrier: ☐ Yes ☐ No

OVER →

Emergency Information

In case of an emergency please contact _____

Complete address _____

Phone No. _____

Medical History

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Are you aware of any latex allergies? _____
Yes No Are you aware of any allergies to nickel? _____

Circle "Y' for yes or "N" for no for any of the medical conditions below that you have had or currently have.

Y/N Abnormal bleeding/Hemophilia	Y/N Diabetes	Y/N Hepatitis/Liver problems	Y/N Pneumonia
Y/N Anemia	Y/N Dizziness	Y/N Herpes	Y/N Prolonged Bleeding
Y/N Arthritis	Y/N Epilepsy	Y/N High Blood Pressure	Y/N Radiation/Chemotherapy
Y/N Asthma or Hay Fever	Y/N Gastrointestinal Disorders	Y/N HIV / Aids	Y/N Rheumatic Fever
Y/N Bone Disorders	Y/N Heart Problems	Y/N Kidney problems	Y/N Tuberculosis
Y/N Congenital Heart Defect	Y/N Heart Murmur	Y/N Nervous Disorders	Y/N Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

For office use: Updated on:__/__/____ Changes:_____
Signature:_____ Dr. Shemirani:_____

Dental History

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb/finger sucking habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____

Benefits of Orthodontic Treatment

Orthodontics is an important health service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Successful orthodontic treatment requires a great deal of patient cooperation; this means maintaining excellent oral hygiene, wearing elastics or other appliances as required. If good oral hygiene is not practiced, tooth decay, decalcification (i.e., irreversible white spots), and gum disease can result. Shortening of the roots is observed in a very small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my anonymous diagnostic records may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Shemirani to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Dr. Bobby Shemirani: _____ Date: _____