DANIEL A. FLORES, D.D.S., M.S., P.C.

Practice Limited to Orthodontics
Children and Adults

PATIENT INFORMATION

Patient's Name _____ (Last / First / Middle) Age _____ Sex _____
Address _____ (Street / City / State / Zip)
Home Phone _____ Birthdate _____
E-Mail Address _____ Cell Phone _____ Carrier _____
If patient is a minor, give parent's or guardian's name _____
Patient's General Dentist _____ Patient's Physician _____
Patient's Occupation/Grade _____ Employer/School _____
Patient's Interests and/or Hobbies _____
Names and ages of other children in family _____
Names of relatives and/or friends treated in our office _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____ (Last / First / Middle / Marital Status)
Mailing Address _____ (Street / City / State / Zip)
Cell Phone _____ Carrier _____
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____
_____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ (Last / First / Middle) Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
_____ Birthdate _____ Work Phone _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____

INSURANCE INFORMATION

Insured's Name _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes ☐ No ☐ If Yes:
Insured's Name _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____

I hereby certify that the above information is correct.

Signature (Parents signature if minor) _____ Date _____
Updates (date & initial) _____ _____ _____ _____ _____

PLEASE COMPLETE OTHER SIDE OF THIS FORM

210 East Fig Street, Suite 201 • Fallbrook, CA 92028 • 760-728-1182
135 East 3rd Avenue, Suite A • Escondido, CA 92025 • 760-745-1831

MEDICAL HISTORY

Date of patient's last medical exam: _____ Height _____ Weight _____

Yes ____ No ____ Is patient in good health? If no, please explain _____

Yes ____ No ____ Has patient ever had a major illness? If yes, what illness? _____

Yes ____ No ____ Does patient have any birth defects? If yes, please explain _____

Yes ____ No ____ Has the patient had a change in health in the last year? If yes, please explain _____

Yes ____ No ____ Has the patient been under the care of a physician in the last year? If yes, please explain _____

Yes ____ No ____ Has patient broken any bones? If yes, please list _____

Yes ____ No ____ Did the broken bones heal satisfactorily? If no, please explain _____

Yes ____ No ____ Have the patient's tonsils and/or adenoids been removed? If yes, when? _____

Yes ____ No ____ Does patient have any drug allergies or sensitivity? If yes, please list _____

Yes ____ No ____ Does patient bleed easily?

Yes ____ No ____ Did patient have a high fever with childhood diseases?

Yes ____ No ____ Does patient have allergies or hay fever? If yes, please list _____

Yes ____ No ____ Has patient ever had psychological counseling? If yes, please explain _____

Yes ____ No ____ Does patient frequently have colds, sore throats or ear infections? If yes, which? _____

Check any of the following for which the patient has been treated or has had a history:

Diabetes	☐	Tuberculosis	☐	Endocrine Problems	☐	Hepatitis	☐
Pneumonia	☐	Anemia	☐	Prolonged Bleeding	☐	Aids	☐
Heart Trouble	☐	Epilepsy	☐	Fainting or Dizziness	☐	Herpes	☐
Rheumatic Fever	☐	Asthma	☐	Nervous Disorders	☐	HIV Positive	☐

DENTAL HISTORY

Date of patient's last dental exam: _____ Date of last dental x-rays: _____

Yes ____ No ____ Is patient aware of any cavities or dental work needed? If yes, what? _____

Yes ____ No ____ Has patient had any injuries to the face, mouth, and/or teeth? If yes, when? _____

Yes ____ No ____ Has patient ever sucked a thumb or fingers? Until what age? _____

Yes ____ No ____ Is patient a mouth breather? While awake? _____ While asleep? _____

Yes ____ No ____ Does patient have a tongue thrust?

Yes ____ No ____ Have you been informed of any missing or extra permanent teeth? Where? _____

Yes ____ No ____ Has either parent or other children had orthodontic treatment? Who? _____

Yes ____ No ____ Does patient frequently get headaches? If yes, how often? _____

Yes ____ No ____ Any pain in or near the ears? Right? _____ Left? _____

Yes ____ No ____ Any clicking or discomfort of the jaw joint near the ears? Right? _____ Left? _____

Yes ____ No ____ Any apprehension or unfavorable experience in a dental office? When? _____

Yes ____ No ____ Has another orthodontist been previously consulted? When? _____

Yes ____ No ____ Has patient ever been placed on an oral hygiene program by a General Dentist? When? _____

Yes ____ No ____ Does patient want to have orthodontic treatment?

Yes ____ No ____ Does patient usually complete work assigned on time?

What is patient's main orthodontic concern(s)? _____

What does patient wish to gain from orthodontic treatment? _____

Today's Date: _____ _____

Signature of Patient, Parent and/or Guardian