IRIS ERDELL DDS,MS ORTHODONTICS

MEDICAL HISTORY FORM

(Please Print)

Today's date (MM/DD/YYYY):						
PATIENT INFORMATION						
❑ Mr. ❑ Mrs. ❑ Ms.	Patient's last name	First	Middle	Birth date	Age	Gender
				/ /		❑F ❑M
Name you like to be called?		Do you play a musical instrument?		If YES, which instrument?		
		❑NO❑YES				
Mailing Address		City		State	ZIP	
Home Phone	Work Phone	Cell Phone	Email address			
( ) -	( ) -	( ) -				
Employer	No. of years employed	Occupation	Social Security No.			
			- -			
How did you hear about our office?	❑ Dr.	❑ Family	❑ Friend	❑Website/Internet		
❑ Insurance	❑ Close to home/work	❑ Yellow Pages	❑ Other:			
Other family members seen here:						
Who may we thank for referring you to our office?						
RESPONSIBLE PARTY				**❑SAME AS ABOVE**		
❑ Mr. ❑ Mrs. ❑ Ms.	Last Name	First	Middle	Marital Status		
				❑Married ❑Single ❑Divorced ❑Widowed		
Social Security No.	Date of Birth	Home Phone	Work Phone	Cell Phone		
- -	/ /	( ) -	( ) -	( ) -		
Address		State	ZIP	Years at this address		
Mailing Address (if different from above)			State	ZIP		
Previous Address (if less than 3 years)			State	ZIP		
Employer	Occupation	No. of years employed	Spouse's name:			
INSURANCE INFORMATION						
Primary Insurance (Please give your insurance card to the receptionist.)						
Insured's name	Insured's Social Security No.	Insured's Date of Birth	Insurance Company			
	- -	/ /				
Insurance Company Address			State	ZIP		
Insurance Company Phone	Insured's Employer	Insured's I.D. # (from card)	Group No.			
( ) -						

t: 925.946.1951 / f: 925.946.1959
218 N. Wiget Lane / Walnut Creek, CA 94598
info@WCOrtho.com / www.WCOrtho.com

Secondary Insurance(Please give your insurance card to the receptionist.)			
Insured's name	Insured's Social Security No.	Insured's Date of Birth	Insurance Company
	- -	/ /	

Insurance Company Address	State	ZIP

Insurance Company Phone	Insured's Employer	Insured's I.D. # (from card)	Group No.
( ) -			

MEDICAL HISTORY

Physician Name	Phone	Dentist Name	Phone
	( ) -		( ) -

Are you currently under any medical treatment?	❑NO ❑YES	Other illness, condition, surgery or problem not listed?	❑NO ❑YES
Do you have pain, clicking, and/or popping noises in the jaw?	❑NO ❑YES	If yes, please list:	
Are you aware of either clenching or grinding of teeth?	❑NO ❑YES	Do you bleed easily?	❑NO ❑YES
Do you have frequent headaches?	❑NO ❑YES	Is there a tendency to faint or become dizzy?	❑NO ❑YES
How often?		Do you have allergies? (**Latex**, sulphur, penicillin, novocaine, nickel, etc.)	❑NO ❑YES
Do you have ear problems? (Aches, ringing, dizziness, fullness)	❑NO ❑YES	If yes, please list:	
Do you have difficulty breathing through the nose?	❑NO ❑YES	Are you currently taking any medication?	❑NO ❑YES
Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting?	❑NO ❑YES	If Yes, please list:	
Have you had your tonsils and / or adenoids removed?	❑NO ❑YES	Have you ever taken any weight loss medication (e.g. PhenFen)?	❑NO ❑YES
Do you have speech problems, or are you in speech therapy?	❑NO ❑YES	Have you ever taken i.v. Bisphosphonates or Oral Bisphosphonates (e.g. Boniva)?	❑NO ❑YES
Do you have sleep apnea?	❑NO ❑YES	Do you have a heart murmur?	❑NO ❑YES
Has there been any history of:		Do you pre-medicate?	❑NO ❑YES

Joint swelling	❑NO ❑YES	Aids	❑NO ❑YES	Are you pregnant?	❑NO ❑YES
Asthma	❑NO ❑YES	Liver Condition	❑NO ❑YES	Do you smoke or chew tobacco?	❑NO ❑YES
TB	❑NO ❑YES	Epilepsy	❑NO ❑YES	Have there been any injuries to the teeth?	❑NO ❑YES
Kidney	❑NO ❑YES	Rheumatic fever	❑NO ❑YES	Were any teeth removed by extractions?	❑NO ❑YES

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home Phone	Work Phone
		( ) -	( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Iris Erdell. I understand that I am financially responsible for any balance. I also authorize Dr. Iris Erdell or insurance company to release any information required to process my claims.I understand that a credit report may be obtained prior to accepting a payment plan.

Patient/Guardian signature	*Date*

Reviewed by	*Date*
Reviewed by	*Date*
Reviewed by	*Date*

CONFIDENTIALITY NOTICE: The information contained on this health form is legally privileged and confidential and is intended only for medical use. Copying or distribution of this document is prohibited.

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