Welcome to

Axelrode
ORTHODONTICS
MORAGA, CALIFORNIA

Dr. Eric L. Axelrode, D.D.S., M.S.D.
Dr. Mark G. Axelrode, D.D.S., M.S.

Welcome to our office. It is our mission to make a positive difference in the lives of our patients by providing excellent orthodontic care with a personal touch. We are dedicated to providing beautiful, healthy smiles that last a lifetime.

1 About you

Today's Date: _____

Name: _____
LAST FIRST MI MR. MRS. MS.

I prefer to be called: _____

Birthdate: ____/____/____ Age: _____ ☐ Male ☐ Female

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #:(____)_____ Cell: (____) _____

Wk #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

How long there?_____Occupation _____

Best daytime phone number: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

General dentist: _____

2 Spouse Information

His/Her Name: _____

Employer: _____

Wk #:(____)_____ Cell: (____) _____

Birthdate: ____/____/____ SS# _____

3 Person Responsible for account:

Name: _____ Relation: _____
LAST FIRST MI MR. MRS. MS.

Billing Address _____

Cell #: (____)_____ Wk #: (____)_____ Hm #: (____) _____

Email: _____

Employer: _____

4 Orthodontic Insurance

PRIMARY

Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone #: (_____) _____

I.D. Number _____

Group Number _____

Policy Owners Name: _____

Relationship to Patient: _____

Policy Owners Birthdate: ____/____/____ SS # _____

Policy Owners Employer: _____

SECONDARY

Orthodontic Coverage ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone #: (_____) _____

I.D. Number _____

Group Number _____

Group Plan # (Plan., Local, or Policy #) _____

Policy Owners Name: _____

Relationship to Patient: _____

Policy Owners Birthdate: ____/____/____ SS # _____

Policy Owners Employer: _____

5

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____) _____

Orthodontics for Adults and Children

6 Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone#: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/ over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For Women:

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Anemia/Radiation Treatment
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes Tuberculosis (TB)
Y N Difficulty breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting
Y N Fever Blisters/Herpes
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+ /AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems

Please list any serious medical conditions(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N Aspirin
Y N Dental Anesthetics
Y N Penicillin
Y N Any Metals/Plastics
Y N Erythromycin
Y N Tetracyeline
Y N Codeine
Y N Latex
Y N Other

Please list any other drugs that you are allergic to: _____

_____

7 Dental History

What are the main concerns that you would like orthodontics to accomplish: _____

_____

_____

Have you ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Have you ever had a serious /difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ I TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? Yes No Gums ever bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin
(Please Circle)

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please circle: While awake? While Asleep?

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment to my attending Orthodontist. I understand that am financially responsible for any charges not covered by this authorization. I also authorize release of any information relating to claims. I understand that, where appropriate, credit bureau reports may be obtained.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDS and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctors Comments:

_____ initials:_____ Date:_____

_____ initials:_____ Date:_____

_____