## Shannon Simons, D.D.S. APDC Katherine O'Friel, D.D.S., MS

Specialist in Orthodontics Children and Adults

## A PROFESSIONAL DENTAL CORPORATION

| Date:  | Patient in                         | ntormation   | NUMBER OF STREET                       |  |
|--|------------------------------------|--|--|--|
|  |                                    | Cassell region to neces-<br>Casses rough services  | A E DAM DEL SU<br>M SE TURK SEKET      |  |
| Patient's Name: First  | Middle Last                        | Prefers to   | o be Called:                           |  |
| Address:   |                                    | ion wind he year orbits in hi  | TENSPOREDS DO. CERT 000 F              |  |
| Patient's Cell Phone:  | City                               | Age:   | State Zip Sex: M / F                   |  |
| If patient is a minor, give parents' or guardian's name:   |                                    |  |  |  |
| School:  | raKicawaD swees                    | Grade:   | Karahi KitabaH L                       |  |
| Whom may we thank for referring  | g you to our office?               | sicolomentoT teve Total  | STUDIES SKITTERES                      |  |
| Siblings/Children Yes/No   | Name/Age                           | Name/Age   | Name/Age                               |  |
| No. control depois such  |                                    | Party Information  |  |  |
| Name:  |                                    | Marital S  | Status:                                |  |
| First  | Middle                             | Last   |  |  |
| Residence:Street   | City                               | State  | Zip                                    |  |
| Mailing Address: Street  | City                               | State  | Zip                                    |  |
| Email address:   |                                    | Cell Phone:  | Work Phone:                            |  |
| Birthdate: Relationship to Patient:  |                                    |  |  |  |
| Employer:  | Occupation                         | on:  | No. Years Employed:                    |  |
| Spouse's Name:   | Middle                             |  | Birthdate:                             |  |
| Spouse's Employer:   |                                    |  | Campa sang off Cia BSY                 |  |
| No. Years Employed:  | Occupation:                        | Cell Pho   | ne:                                    |  |
|  |                                    | nce Information  | 5-1                                    |  |
|  |                                    | Subscriber ID # or SSI   | N #:                                   |  |
| Insured's Employer:  | Openation and or State and rate of | HA SERVICE CONTRACTOR OF THE STATE OF  | o again and the City 258.              |  |
| Insurance Company:   | Group No.:                         |  |  |  |
| Insurance Co. Address:   |                                    | Pendocheed Incom   | Phone:                                 |  |
| Do you have dual coverage?   | ☐ Yes ☐ No                         | ne travelle som et Personali   | 1 Marie 2 Per 2000 Co. 2000            |  |
|  | Previous Ortho                     | dontist Information  |  |  |
| If transferred, name of previous orthodontist:   |                                    |  |  |  |
| Address:   |                                    |  |  |  |
| Phone:Emergency Information  |                                    |  |  |  |
| Since an engagement of the substance of the body process of the substance and the substance and the substance of the substanc |                                    |  |  |  |
| Name of person to contact in ca  | se of an emergency:                | or the special control of the special control | 1975年,新市场等在中间,1975年                    |  |
| Phone:   | Relationship:                      | calculativem abones seemed block   | such covered medic and beautication. I |  |

Confidential

|   | 15   | Medical History  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| Primary Care P  | Physician:   | <u>emanne Offdet, O.D.S. Jet</u>   | Date of Last Visit:   |  |  |  |  |
| Please circle Ye  | es or No (if Yes, please fill in de  | tails)   |   |  |  |  |  |
| YES NO Are you taking any medications? YES NO Are you allergic to any medications? YES NO Do you have a history of major illness? YES NO Have you had any major operations?   |  |  |   |  |  |  |  |
| YES NO Have you ever been involved in a serious accident?   |  |  |   |  |  |  |  |
| YES NO  | Do you require an antibiotic pr  | ior to dental cleanings?   |   |  |  |  |  |
| Circle any of the medical conditions below that you have had or currently have.   |  |  |   |  |  |  |  |
| AIDS/HIV<br>Bone Disorders<br>Hepatitis<br>Heart Problems<br>Pneumonia<br>Prolonged Blee  | Herpes<br>Kidney Disorder<br>Rheumatic Fever   | Arthritis Dizziness High Blood Pressure Liver Disorder Tuberculosis  | Asthma or Hayfever Epilepsy Gastrointestinal Disorders Nervous disorder Tumor or Cancer |  |  |  |  |
| Are there any medical conditions we have not discussed that you feel we should be aware of? YES NO  If child, have you reached puberty? Girls-have you started menstruation:Boys-has your voice changed:  Is your child adopted? YES NO |  |  |   |  |  |  |  |
|   | COUNTY OF THE PROPERTY OF THE  | Dental History   |   |  |  |  |  |
|   |  |  |   |  |  |  |  |
| Dentist:  | etus.  |  | Date of Last Visit:Phone:   |  |  |  |  |
| Address:  | e de la constante de la consta | 100 Miles  | Date of Last Visit:Phone:   |  |  |  |  |
| Address: What concerns YES NO   | s you most about your teeth?   | fort?  | Phone:  |  |  |  |  |
| Address:  | Are you in any pain or discom  | fort?<br>ny unfavorable reaction to de   | ntistry?  |  |  |  |  |
| What concerns YES NO YES NO YES NO YES NO YES NO  | Are you in any pain or discom Have you ever experienced at Have you ever lost or chipped Have there been any injuries  | fort?<br>ny unfavorable reaction to del<br>I any teeth?<br>to face, mouth or teeth?  | ntistry?  |  |  |  |  |
| Address:  What concerns  YES NO YES NO YES NO   | Are you in any pain or discom Have you ever experienced at Have you ever lost or chipped Have there been any injuries to   | fort?ny unfavorable reaction to dell any teeth?to face, mouth or teeth?sitive to temperature or pressi                                 | ntistry?  |  |  |  |  |
| Address:  What concerns  YES NO   | Are you in any pain or discom Have you ever experienced at Have you ever lost or chipped Have there been any injuries to Is any part of your mouth sens Do your gums bleed when you Do you have any type of thum   | fort?  | ntistry?  |  |  |  |  |
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Orthodontics is a service that provides improvements in the appearance of the teeth, in the general function of the teeth and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums may result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I hereby certify that I have reviewed the above health history and that it is accurate to my knowledge at this time. If there are any future changes in this information, I will inform the office of these changes. This

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