Fast Braces® Fresno DBA: Fast Dental Fresno

New Patient Welcome Form

Patient Information			
Patient's Last Name:	First:		Middle:
Social Security Number:		Home Phone #:	
Birth date: / /	Age:	Sex: M ☐ F ☐	Cell/Other Phone #:
Home Address:		Email:	
City:	State:	Zip:	
Employer:			
Whom may we thank for referring you?			
General Dentist:		Last Visit Date:	
Dentist Phone #:			
Other Family Members Who Come Here?			

Responsible Party's Information			
Relationship to Patient:			
Last Name:	First:		Middle:
Employer:		Home Phone #:	
Birth date: / /	Age:	Sex: M☐ F☐	Cell/Other Phone #:
Home Address:		Email:	
City:	State:	Zip:	
Marital Status: Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated ☐			

Dental Insurance Information:			
Primary Insurance			
Policy Holder's First Name:		Policy Holder's Last Name	
Birth date: / /	Social Security Number:		Occupation:
Employer:			
Employer Address:			
City:		State:	Zip:
Insurance Company Name:			
Insurance Company Address:			
City:		State:	Zip:
Phone #:	Policy/ Member ID#:		Group #:
Secondary Insurance			
Policy Holder's First Name:		Policy Holder's Last Name	
Birth date: / /	Social Security Number:		Occupation:
Employer Address:			
City:		State:	Zip:
Insurance Company Name:			
Insurance Company Address:			
City:		State:	Zip:
Phone #:	Policy/ Member ID#:		Group #:

Authorization

I understand that I am responsible for the payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance company does not cover. I authorize the dentist to release all information necessary to secure the payment of benefits. I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

Signature of Responsible Party:	**Date:**

Medical History

Does the Patient have a Physician? Yes ☐ No ☐	Physician Name:	Phone #:
Patient's Current Physical Health is: Good ☐ Fair ☐ Poor ☐	Are the Patient's immunizations current: Yes ☐ No ☐	
Is the Patient's under the care of Physician? Yes ☐ No ☐ Please Explain:		
Is the Patient's currently taking and prescription/ over-the-counter drugs? Yes ☐ No ☐ Please list names:		
For Women: Are you pregnant? Yes ☐ No ☐	# Of Weeks?	Nursing? Yes ☐ No ☐

Has the Patient ever had any of the following diseases or medical problems now or in the past:

Yes ☐ No ☐	Abnormal Bleeding/ Hemophilia	Yes ☐ No ☐	Skin Disorder
Yes ☐ No ☐	ADD/ ADHD	Yes ☐ No ☐	Prosthetics
Yes ☐ No ☐	AIDS or HIV positive	Yes ☐ No ☐	Rheumatic Fever
Yes ☐ No ☐	Any hospital stays/Operations	Yes ☐ No ☐	Scarlet Fever
Yes ☐ No ☐	Artificial Bones/Joints/ Valves	Yes ☐ No ☐	Sickle Cell Disease/ Traits
Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Tuberculosis (TB)
Yes ☐ No ☐	Bone Fractures or any Major Accidents	Yes ☐ No ☐	Diabetes
Yes ☐ No ☐	Any Injuries to the face, head, neck	Yes ☐ No ☐	Epilepsy
Yes ☐ No ☐	Birth Defects or Hereditary Problems	Yes ☐ No ☐	Handicap/ Disabilities
Yes ☐ No ☐	Congenital Heart Defect	Yes ☐ No ☐	Stomach Ulcer/Hyperacidity, acid reflux
Yes ☐ No ☐	Convulsions	Yes ☐ No ☐	Eating disorder (anorexia, bulimia)
Yes ☐ No ☐	Cancer/Tumor/Radiation/Chemotherapy	Yes ☐ No ☐	Rheumatoid or Arthritic Problems
Yes ☐ No ☐	Hearing, Vision, or Speech Problems	Yes ☐ No ☐	Immune System Problems
Yes ☐ No ☐	Tonsil or adenoid condition	Yes ☐ No ☐	Liver Problems
Yes ☐ No ☐	Mitral Valve Prolapsed	Yes ☐ No ☐	Kidney Problems
Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Hepatitis
Yes ☐ No ☐	Hemophilia	Other:	

Is the Patient allergic or had a reaction to any of the following:

Yes ☐ No ☐	Local Anesthetics (Novocain or Lidocaine)	Yes ☐ No ☐	Metals (Nickel, Jewelry, Clothing snaps)
Yes ☐ No ☐	Aspirin	Yes ☐ No ☐	Latex (gloves, balloons)
Yes ☐ No ☐	Ibuprofen (Motrin, Advil)	Yes ☐ No ☐	Acrylic
Yes ☐ No ☐	Penicillin or other Antibiotics	Yes ☐ No ☐	Plastic
Yes ☐ No ☐	Food (Mint, Cinnamon, Citrus or other)	Other:	

Dental History

What are the main orthodontic concerns you would like to accomplish?

Has the patient ever been evaluated for orthodontic treatment? No ☐ Yes ☐ When?

Has the patient ever had a serious/ difficult problem associated with any previous dental work? No ☐ Yes ☐ When?

Has the Patient ever had any of the following now or in the past:

Yes ☐ No ☐	Any dental pain	Yes ☐ No ☐	Sore or Sensitive Teeth
Yes ☐ No ☐	Permanent or Extra teeth removed	Yes ☐ No ☐	Bleeding gums, bad taste or mouth odor
Yes ☐ No ☐	Extra or congenitally missing teeth	Yes ☐ No ☐	Jaw Fractures, cysts, infections
Yes ☐ No ☐	Chipped or injured teeth	Yes ☐ No ☐	Frequent oral habits (sucking finger, chewing pens, etc)
Yes ☐ No ☐	Root canals or pulpotomies	Yes ☐ No ☐	Thumb or tongue habit
Yes ☐ No ☐	Jaw clenching, clicking or popping	Yes ☐ No ☐	Grinding of the teeth
Yes ☐ No ☐	Difficulty breathing through nose	Yes ☐ No ☐	Mouth breathing or snoring at night
Yes ☐ No ☐	Gum disease or pyorrhea	Yes ☐ No ☐	Speech problems

Release and Waiver

I understand that the information I have given is correct to the best of my knowledge, that it will be held strictest confidence and that it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature of Responsible Party: **Date:**