VISTANCIA ORTHODONTICS

Devin L Croft DDS, MS
9772 W. Yearling Rd. A1600
Peoria, Az 85383
623-566-0800

Patient Information

Date ___________________________

Patient's Name ____

Last First Middle

Address____

Street City State Zip phone

Nickname ________________________ Birthdate _____________ Age______ Sex ____ Social Security # _____________________

If patient is a minor, give parent or guardians' name ____

Whom may we thank for referring you to our office? ____

Responsible Party Information

Name ____ _________________

Last First Middle Marital Status

Residence ____

Street City State Zip

Mailing Address ____

Street City State Zip

How long at this address? _____________ Home Phone _________________________ Work Phone __________________________

Previous Address (if less than 3 yrs) ____

Street City State Zip

Social Security # ___________________________ Birthdate ____________________ Relationship to Patient __________________

Employer _________________________________ Occupation __________________ No. Years Employed ___________________

Spouse's Name ____ Relationship to Patient __________________

Last First Middle

Employer _________________________________ Occupation __________________ No. Years Employed ___________________

Social Security # ___________________________ Birthdate ____________________ Work Phone __________________________

Email address ____ preferred method of contact: Phone, Email, Text

Insurance Information

Insured's Name ____ Insured's Social Security #__________________________

Insurance Company ____ Group Number __________________________________

Insurance Co. Address ____ Phone ____

Insured's Employer____

Do you have secondary coverage? (circle one) YES NO If yes: ____

Insured's Name ____ Insured's Social Security #__________________________

Insurance Company ____ Group Number __________________________________

Insurance Co. Address ____ Phone ____

Insured's Employer ____

Emergency Information

Name of nearest relative not living with you ____
Complete Address ____
Phone Number ____

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

Signature (Parent's signature if minor) ____

Update Signature ______________________________ Update Signature ______________________________

Date Date

Medical/Dental History

Patient Name ______________________

What is your chief concern for us at this visit? ____

____

**Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.

Medical History

Y N Are you in excellent health?
Y N Has there been any change in your general health within the last year?
Y N My last physical exam was ____________(month/year)
Y N Are you now under the care of a physician? If so, what is being treated? ______________________
Y N Have you had a serious illness/hospitalization in the past 5 years?
If so, for what? ____
Y N Are you taking any medication (incl. non-prescription)?______________________________

Do you have any of the following conditions?

Allergies or drug reactions to:

Y N Latex
Y N Penicillin or other antibiotics
Y N Sulfa drugs
Y N Aspirin, Ibuprofen, Tylenol
Y N Local anesthetics
Y N Codeine or other narcotics
Y N Other ___________________________
Y N Respiratory problems, emphysema
Y N Asthma or hay fever
Y N Sinus trouble
Y N Persistent swollen neck glands
Y N Thyroid or endocrine problems
Y N Diabetes
Y N Hepatitis, jaundice or liver disease
Y N AIDS or HIV infection

Y N Abnormal bleeding or blood transfusion
Y N Low blood pressure
Y N Cardiovascular disease (heart trouble, attack, angina, high blood pressure, arteriosclerosis, stroke)
Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease
Y N Arthritis or joint problems or artificial joints/limbs
Y N Require pre-medication before dental visits?
Y N Birth Defects
Y N Kidney trouble
Y N Tuberculosis
Y N Bone fractures or trauma to face or jaw
Y N Vision, hearing or speech difficulty
Y N Persistent Cough
Y N Frequent colds or sore throats

Y N Sexually transmitted disease
Y N Substance abuse problem (past or present)
Y N Mental health problem or nervous disorder
Y N Fainting spells or seizures
Y N Epilepsy or other neurological disease
Y N Fainting spells or seizures
Y N Blood disorder such as anemia
Y N Frequent headaches
Y N Stomach ulcer or hyperacidity
Y N Tumor (Cancerous or benign)
Y N Radiation therapy or Chemotherapy
Y N Females: Are you pregnant?
Y N Do you have any disease, condition or problem not listed above that you think we should know about?

If so, please explain ____

Dental History

Name of patient's dentist ______________________ Date of last dental exam ______________________

Y N Chipped or injured permanent teeth
Y N Teeth sensitive to hot or cold
Y N Jaw fractures, cyst, mouth infections
Y N Previous root canal therapy
Y N Bleeding gums or bad taste/mouth odor
Y N Other periodontal (gum) problems
Y N Problems with food trapped between teeth
Y N Frequent canker sores or cold sores
Y N Mouth breathing habit or snoring troubles
Y N Abnormal swallowing (tongue thrust)
Y N Have you had a negative dental experience?
Y N History of missing or extra teeth
Y N Have any permanent teeth been removed?
Y N Have wisdom teeth been removed?
Y N Teeth that irritate tongue, cheek, lip, etc.
Y N Previous orthodontic treatment or retainer
Y N Previous periodontal (gum) treatment
Y N Numerous fillings
Y N Damaged restorations or fillings
Y N Thumb or finger habit as a child
Y N Loose or shifting teeth
Y N Is all dental work completed at this time?

TMJ History

Y N Have you had a TMJ screening?
Y N Do you have a history of jaw joint problems?
Y N Have you been treated for "TMJ"?
Y N Do you grind your teeth?
Y N Do you clench your teeth?
Y N Has your jaw ever locked?
Y N Does your bite feel uncomfortable or unusual?
Y N Do you have pain in your jaw joint?
Y N Do you experience soreness in the muscles of your face or around ears?
Y N Do you notice clicking or popping in your jaw joint?
Y N Do you have difficulty chewing or opening your mouth?

**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any changes later to this history record or medical or dental status, I will inform the practice.

____

Signature of Patient Date

______________________________ ______________________________

Update Signature Date Update Signature Date

______________________________ ______________________________

Update Signature Date Update Signature Date