

# Welcome



# to the orthodontist

*“Changing lives one smile at a time”*

robert sheffield dds inc

SPECIALIST IN ORTHODONTICS & DENTOFACIAL ORTHOPEDICS

3428 Hillcrest Ave., Suite 100  
Antioch, CA 94531  
925-757-9100

1140 Second Street, Suite C  
Brentwood, CA 94513  
925-634-4446

www.sheffieldortho.com

## Patient Information

Date \_\_\_\_\_ Patient # \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

I Prefer to be called \_\_\_\_\_

Male  Female Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Hobbies / Interests / Sports \_\_\_\_\_

\_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How Long? \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Where & when are the best times to reach you? \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Email Address \_\_\_\_\_

Sibling(s) and Age(s) \_\_\_\_\_

Other family members seen by us \_\_\_\_\_

If patient is a minor, parent's or guardian's name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Do you have legal custody Yes  No

General Dentist \_\_\_\_\_

Last Cleaning Date \_\_\_\_\_

Whom may we THANK for referring you? \_\_\_\_\_

**Payment is due in full at the commencement of treatment**  
*(Unless prior arrangements have been approved)*

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Orthodontic Insurance

Orthodontic Insurance Coverage? Yes  No

Dual Coverage? Yes  No

Primary Insured Name \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_

Group # \_\_\_\_\_

(Plan #, Local #, Policy #)

Secondary Insured Name \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's ID # \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_

Group # \_\_\_\_\_

(Plan #, Local #, Policy #)

## Responsible Party Information

Name \_\_\_\_\_

Patient is your \_\_\_\_\_

Address, City, Zip \_\_\_\_\_

\_\_\_\_\_

How long at this address \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_

\_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_

How long? \_\_\_\_\_ Position \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_

How long \_\_\_\_\_ Position \_\_\_\_\_

Work # \_\_\_\_\_ Cell # \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Continued on Back

# Medical & Dental History

What are the main concerns about the teeth and/or smile?

---

---

---

Has your child ever been evaluated or had orthodontic treatment before?  Yes  No

Name \_\_\_\_\_

Location \_\_\_\_\_

Have there been any injuries to the face, mouth, teeth or chin?  Yes  No

Describe: \_\_\_\_\_

Have you been advised to take antibiotics prior to dental treatment?  Yes  No

Have adenoids or tonsils been removed?  Yes  No

Have you been informed that your child is missing or has extra permanent teeth?  Yes  No

Has your child ever had any pain/tenderness in jaw joint (TMJ)?  Yes  No

Does your child brush his/her teeth daily?  Yes  No

Floss his/her teeth daily?  Yes  No

Has puberty begun?  Yes  No

Has menstruation begun?  Yes  No

Child's Physician \_\_\_\_\_

Phone # \_\_\_\_\_

Your child's current physical health is:  Good  Fair  Poor

List all drugs that your child is currently taking: \_\_\_\_\_

---

List all drugs that your child is allergic to: \_\_\_\_\_

---

Has your child ever had any of the following medical problems?

Y N Heart Murmur	Y N Congenital Heart Defect
Y N HIV+ / Aids	Y N Any Operations
Y N Diabetes	Y N Handicaps / Disabilities
Y N Cancer	Y N Convulsions / Epilepsy
Y N Allergic to Plastic	Y N Abnormal Bleeding
Y N Rheumatic Fever	Y N Hearing Impairment
Y N Hemophilia	Y N Any stays in a hospital
Y N Asthma	Y N Kidney / Liver Problems
Y N Hepatitis	Y N Allergic to Latex / Metals
Y N Tuberculosis (TB)	Y N Phen / Fen

Please discuss any medical problems that your child has had:

---

---

---

Does your child have any of the following habits?

Y N Thumb / Finger Sucking	Y N Mouth Breather
Y N Lip Sucking / Biting	Y N Speech Problems
Y N Clenching / Grinding Teeth	Y N Nail Biting
Y N Nursing Bottle Habit	Y N Tongue Thrust

## Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during the diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

I wish to obtain a copy of my credit report  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Emergency Contact Info

In the event of an emergency, contact:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Cell # \_\_\_\_\_

Work # \_\_\_\_\_

Home # \_\_\_\_\_

**Our office is HIPPA compliant and is committed to meeting or exceeding that standards of infection mandated by OSHA, the CDC and the ADA.**