

Welcome



to the orthodontist

“Changing lives one smile at a time”

robert sheffield dds inc

SPECIALIST IN ORTHODONTICS & DENTOFACIAL ORTHOPEDICS

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Antioch, CA 94531
925-757-9100

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Brentwood, CA 94513
925-634-4446

www.sheffieldortho.com

About You

Date _____ Patient # _____

Name _____
Last First Middle

I Prefer to be called _____

Male Female

Home Address _____

City _____ State _____ Zip _____

How Long? _____

Home # _____ Cell # _____

Birthdate _____ SS# _____

Email Address _____

Person Responsible for Account _____

Single Married Divorced Widowed Separated

Hobbies / Interests _____

Other family members seen by us _____

Employer _____

Position _____ How Long? _____

Work # _____ Ext. _____

Where & when are the best times to reach you? _____

General Dentist _____

Last visit date _____

Whom may we THANK for referring you? _____

Spouse Information

Name _____

Employer _____

Position _____ How Long? _____

Work # _____ Ext. _____

Cell # _____

Spouse SS # _____

Spouse Birthdate _____

Orthodontic Insurance

Orthodontic Insurance Coverage? Yes No

Dual Coverage? Yes No

Primary Insured Name _____

SS# _____

Insured's Employer: _____

Insured's ID #: _____

Ins. Co. Name _____

Ins. Co. Phone # _____

Group # _____

(Plan #, Local #, Policy #)

Secondary Insured Name _____

SS# _____

Insured's Employer: _____

Insured's ID #: _____

Ins. Co. Name _____

Ins. Co. Phone # _____

Group # _____

(Plan #, Local #, Policy #)

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 _____

Medical & Dental History

Do you have a personal physician? Yes No

Physician's Name _____

Phone # _____

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 _____

Have you ever taken any diet medications (prescription or herbal)? Yes No

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

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

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

Are you allergic to any of the following items?

- | | | |
|------------------|------------------------|-----------------------|
| Y N Penicillin | Y N Tetracycline | Y N Latex |
| Y N Aspirin | Y N Dental Anesthetics | Y N Any Metal/Plastic |
| Y N Erythromycin | Y N Codeine | Y N Other |

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

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

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

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

Have you ever experienced pain/discomfort in your jaw joint (TMJ)? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

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

Do you have any of the following habits?

- | | |
|--------------------------------|-------------------|
| Y N Lip Sucking / Biting | Y N Nail Biting |
| Y N Clenching / Grinding Teeth | 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.