FRANK YORITA, D.D.S., B.D.S. **SPECIALIST IN ORTHODONTICS**
(714) 893-7539 **www.orthodontic.org** **and invisalign®**

Adult Patient Information

Date: _____ Comp#: _____

Patient's Name _____ Nickname _____

Address _____ City _____ Zip _____

Home Phone _____ Birth Date ___/___/___ Age ___ Sex ___

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

General Dentist _____ City _____ Phone _____

Date of last dental check-up and cleaning? _____ Last x-rays taken _____

Family member(s) in treatment _____

How long at this address _____ ❑ Rent ❑ Own Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____

Social Security Number ___-___-___ Birth Date ___/___/___

Employer _____ Occupation _____ No Years Employed ___

Spouse's Name _____

Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____

Social Security Number ___-___-___ Birth Date ___/___/___

Employer _____ Occupation _____ No Years Employed ___

Person financially responsible for this account ❑ Father/Self ❑ Mother ❑ Other _____

Marital status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Dental Insurance Information

Insured's Name _____ Birth Date ___/___/___ SSN ___-___-___

Insurance Company _____ Group No _____ Local No _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? ❑ Yes ❑ No

2nd Insured's Name _____ Birth Date ___/___/___ SSN ___-___-___

Insurance Company _____ Group No _____ Local No _____

Insurance Co. Address _____ Phone _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____ City _____ Zip _____

Phone _____

This office reserves the right to verify the credit status of potential patients seeking payment terms.

List of favorite hobbies or interest: _____

Medical History

Medical Physician Name: _____ Phone #: _____

Are you in Good Health? ❑ Yes ❑ No

Do you have a history of major illness? ❑ Yes ❑ No

Have you been under the care of a physician for a major illness? ❑ Yes ❑ No

ASTHMA	❑ Yes	❑ No	CANCER	❑ Yes	❑ No	HIGH BLOOD PRESSURE	❑ Yes	❑ No
DIABETES	❑ Yes	❑ No	ANEMIA	❑ Yes	❑ No	PROLONGED BLEEDING	❑ Yes	❑ No
PNEUMONIA	❑ Yes	❑ No	EPILEPSY	❑ Yes	❑ No	PAINTING OR DIZZINESS	❑ Yes	❑ No
HEART TROUBLE	❑ Yes	❑ No	NERVOUS DISORDER	❑ Yes	❑ No	LIVER INVOLVEMENT	❑ Yes	❑ No
RHEUMATIC FEVER	❑ Yes	❑ No	TUBERCULOSIS	❑ Yes	❑ No	KIDNEY INVOLVEMENT	❑ Yes	❑ No
BONE DISORDERS	❑ Yes	❑ No	TMJ/TMD SYMPTOMS	❑ Yes	❑ No	ENDOCRINE PROBLEMS	❑ Yes	❑ No
HEPATITIS	❑ Yes	❑ No	AIDS/HIV	❑ Yes	❑ No	VENEREAL DISEASE	❑ Yes	❑ No
						NONE OF THE ABOVE	❑	

Have tonsils and adenoids been removed? What age? ❑ Yes ❑ No

Are you a mouth breather? ❑ Yes ❑ No

List any drugs or medications now being taken. Give reason: _____

List any known allergies or drug sensitivities: _____

Do you have any reaction / allergies to latex (gloves) products? ❑ Yes ❑ No

Height _____ Weight _____

Dental History

Have there been injuries to the face, mouth, or teeth? ❑ Yes ❑ No
Is snoring or sleep apnea a problem? ❑ Yes ❑ No
Any jaw symptoms such as clicking or locking? ❑ Yes ❑ No
Is clenching or grinding of teeth a problem? ❑ Yes ❑ No
Have you ever sucked a thumb or finger? Until what age? ❑ Yes ❑ No
Do you have any speech problems? ❑ Yes ❑ No
Have you been informed of any missing or extra permanent teeth? ❑ Yes ❑ No
Has an orthodontist been consulted previously? ❑ Yes ❑ No
Has either parent or patient had orthodontic treatment? ❑ Yes ❑ No
Do you require premedication (antibiotics) prior to dental treatment? ❑ Yes ❑ No
Chief concern _____

PATIENTS' SIGNATURE: _____ Date: _____

Reviewed by Dr.: _____