

David A. Tabata, D.D.S. Orthodontics

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Patient Information

Date _____
Patient's Name _____
Last First Middle
Address _____
Street City State/ZIP
Home Phone _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's or guardian's name _____
Hobbies _____
Dentist _____ How did you hear of 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 years) _____
Street City State/ZIP
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. address _____
Insured's Employer _____
Do you have dual coverage? Yes No If yes:
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. address _____
Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete address _____
Phone _____

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

Signature (Parent's signature if minor) _____
Updates (date & initial) _____

Please complete the following (check one):

Is patient in good health?..... Yes No

Is patient under physician's care, or has been in the past 2 years?..... Yes No

Is patient subject to profuse bleeding?..... Yes No

Is patient subject to nervous disorders, fainting, etc.?..... Yes No

Is patient sensitive to any drugs?..... Yes No

Do you or your child have a history of sensitivity to latex?..... Yes No

Has patient any history of heart trouble, diabetes, asthma, kidney or liver involvement, allergy or any other constitutional disorders? (If yes, please underline disorder.)..... Yes No

Has patient ever tested positive for HIV or hepatitis?..... Yes No

Has patient experienced any unfavorable reaction from any previous dental treatment?..... Yes No

List any habits affecting teeth: _____ Yes No

Have you or are you taking Phen-Phen?..... Yes No

Has any member of the family had orthodontic treatment?..... Yes No

OTHER CHILDREN IN FAMILY:

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Signature of responsible party: _____

FOR OFFICE USE ONLY:

Clinical diagnosis _____

Fee Quoted _____ Fee for Retention _____

1. Maxillary anterior teeth: spaced; protrusive; crowded; deep overbite; nicely aligned.

2. Lip posture fullness _____

3. Finger sucking habit _____

4. Tongue thrust _____

5. Remove dental units _____

6. Observation _____

7. Diagnostic records: full; minor.

8. Treatment: full; minor.

9. TMJ: _____

Clicking _____

Oral Cancer Screening _____

Periodontal Exam: _____

Molars	Cuspid	Overbite	Profile	Overjet
Class I ()	Class I ()	Open ()	Straight ()	Normal ()
Class II ()	Class II ()	Normal ()	Convex ()	Moderate ()
Class III ()	Class III ()	Closed-Moderate ()	Concave ()	Severe ()
Subdivision:	Subdivision:	Severe ()	Double	
Right ()	Right ()		Protrusion ()	
Left ()	Left ()			
Crossbite	Arch	Midline Off	Crowding	
None ()	Assymetry	Max ()	Max Mod ()	Severe ()
Post ()	Max ()	Mand ()	Mand Mod ()	Severe ()
Ant ()	Mand ()	Right ()		
		Left ()		

Signature: _____
