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Today's Date _____

Tell Us About Yourself

Name: _____ Female Male Age: _____ Date of Birth: _____ Miss Ms Mrs Mr
 Address: _____ Unit #: _____ City: _____ State: _____ Zip: _____ SS#: _____
 Own Rent How long there? _____ Single Married Separated Divorced Widowed Person Responsible for this Account: _____
 Home Phone #:(____) _____ Work #:(____) _____ Cell #:(____) _____ Email: _____ DL #: _____
 Whom may we thank for referring you? _____ Other family members seen by us: _____
 General Dentist Name: _____ DDS Phone #:(____) _____ DDS Address: _____
 Employer: _____ Position: _____ Employer Address: _____ How long there? _____

Spouse Information

Spouse's Name: _____ Date of Birth: _____ DL#: _____ SS#: _____ Email: _____
 Employer: _____ Position: _____ Employer Address: _____ How long there? _____

Orthodontic Insurance

Primary Insurance

Orthodontic Coverage Yes No Dental Coverage Yes No
 Insurance Co Name: _____ Insurance Phone #: _____ Group #: _____
 Insurance Address: _____ City: _____ State: _____ Zip: _____
 Insured's Name: _____ Relation to Patient: _____ Insured's Date of Birth: _____
 Insured's ID#: _____ Insured's SS#: _____ Insured's Employer: _____

Secondary Insurance

Orthodontic Coverage Yes No Dental Coverage Yes No
 Insurance Co Name: _____ Insurance Phone #: _____ Group #: _____
 Insurance Address: _____ City: _____ State: _____ Zip: _____
 Insured's Name: _____ Relation to Patient: _____ Insured's Date of Birth: _____
 Insured's ID#: _____ Insured's SS#: _____ Insured's Employer: _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I agree and accept that this office reserves the right to verify credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered. I understand I am responsible for paying any co-payment and deductibles my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and, I assign directly to the doctor, all insurance benefits otherwise payable to me. I further authorize the use of my signature on all my insurance submissions, whether manual or electronic.



Signature _____

Date _____

Dental & Medical History

What is your main concern? _____

Are you happy with your smile? Yes No If not, what would you change? _____

Have you been evaluated or had orthodontic treatment before? Yes No Do you have any speech problems? Yes No

Have you ever had a serious problem in the past with dental work? Yes No Do you still have your wisdom teeth? Yes No

Have there been any injuries to your mouth/teeth/chin/face? (please circle) Yes No Do you have any missing or extra teeth? Yes No

Have you had any implants, pins or metal rods? (please circle) Yes No Do you require antibiotics prior to dental work? Yes No

Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)? Yes No Do you smoke or use tobacco in any other form? Yes No

Do you generally breathe through your mouth? Yes No If yes, please circle: While Awake? While Asleep?

Have you ever taken any diet pills, such as Phen-Fen? Yes No (Also known as Redux or Pondimin.) If so, when? _____

Please list all prescription and over the counter drugs that you are currently taking: _____

Do you have a personal physician? Yes No Name: _____ Phone#: _____ Date of Last Visit: _____

Are you currently under the care of a physician? Yes No If yes, please explain: _____

Please describe your current dental health: Good Fair Poor Please describe your current physical health: Good Fair Poor

For Women: Are you taking birth control? Yes No Are you pregnant? Yes No # of weeks: _____ Are you nursing? Yes No

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

Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Pacemaker	Y	N
AIDS	Y	N	Frequent Headaches	Y	N	Psychiatric Problems	Y	N
Alcohol or Drug Abuse? (please circle)	Y	N	Glaucoma	Y	N	Radiation Treatment	Y	N
Anemia	Y	N	Hay Fever or Scarlet Fever (please circle)	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Seizures	Y	N
Artificial Bones/Joints/Valves (please circle)	Y	N	Heart Murmur	Y	N	Shingles	Y	N
Asthma	Y	N	Hepatitis: Type _____	Y	N	Sickle Cell Disease	Y	N
Blood Transfusion	Y	N	Herpes or Fever Blisters (please circle)	Y	N	Sinus Problems	Y	N
Cancer: Type _____ Chemotherapy	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Colitis	Y	N	HIV	Y	N	Surgery: for what _____	Y	N
Congenital Heart Defect	Y	N	Kidney Problems	Y	N	Thyroid Problems	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Traits	Y	N
Difficulty Breathing	Y	N	Low Blood Pressure	Y	N	Tuberculosis (TB)	Y	N
Emphysema	Y	N	Lupus	Y	N	Ulcers	Y	N
Epilepsy	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N

Please list any serious medical conditions or hospital stays that you have ever had: _____

Are you allergic to any of the following?

Aspirin	Y	N	Erythromycin	Y	N	Latex	Y	N
Codeine	Y	N	Jewelry	Y	N	Penicillin	Y	N
Dental Anesthetics	Y	N	Metals	Y	N	Tetracycline	Y	N

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

I understand that all 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 or dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify 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.

Patient Signature _____ **Date** _____

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist _____ Date _____

Dentist's Comments: _____

Has there been any change in your health status since your last visit? Y N

If Yes, please explain: _____

Patient Signature _____ **Date** _____

Dentist Signature _____ Date _____

Has there been any change in your health status since your last visit? Y N

If Yes, please explain: _____

Patient Signature _____ **Date** _____

Dentist Signature _____ Date _____