



(858) 800-2000

Happiness starts Here: Smile!

J. SHAHANGIAN, DDS, MS, INC

ALPINE

ORTHODONTICS

(619) 445-8883

JENNIFER BREHOVE, DDS, MS

JOEL TZINBERG DDS, MS

Patient's Name _____ Preferred Name _____

Sex: M F Birth Date: _____ Age _____ School _____ Grade _____

Residence Address _____ Email _____

Cell _____ Who can we thank for referring you to our practice? _____

Marital status: birth parents or self (if adult): Married Divorced Separated Single/Widowed

Patient's Physician _____ Address _____ Phone _____

Patient's Dentist _____ Address _____ Phone _____

FATHER'S INFORMATION (or self if adult)

Name _____ Employer _____ Occupation _____

Address _____ Cell _____ Date of Birth _____

MOTHER'S INFORMATION (or wife/husband if adult)

Name _____ Employer _____ Occupation _____

Address _____ Cell _____ Date of Birth _____

PERSON RESPONSIBLE FOR ACCOUNT

First & Last Name _____ Address _____

Home Phone _____ Work Phone _____ Cell _____

Email _____ (we do most of our communications via email and NEVER spam.)

Orthodontic Insurance? _____ Ins. Company _____ Social Security# _____

MEDICAL INFORMATION

Your estimation of patient's general health: Good Fair Poor

Has there been any change in health in the last year? _____ What? _____

Does patient have any history of major illness? _____ What? _____

List medications being taken and reasons or write "None" _____

Is patient frequently ill? _____ If yes, reason: _____

List any allergies or write "None" _____

List drug sensitivities or write "None" _____

Tonsils removed? _____ Age: _____ Adenoids removed? _____ Age: _____

Boys: voice change? _____ Age: _____ Girls: started period? _____ Age: _____

+18 yrs Girls : pregnant? _____ Months into pregnancy: _____ Date due: _____

Check any of the following for which the patient has a history of:

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic valve/limb etc.
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Kidney involvement
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Hives or skin rash
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Aids	<input type="checkbox"/>	<input type="checkbox"/>	Bone disorders	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine problems
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Disability

Other: _____



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DENTAL HISTORY:

	YES	NO
Any history of injuries to face, mouth, or teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient ever sucked thumb, finger, lip, pen/pencil, etc.? Until what age? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have any speech problems?	<input type="checkbox"/>	<input type="checkbox"/>
Is nasal breathing difficult for patient?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient been informed of any missing permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient been informed of any extra permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have difficulty chewing food?	<input type="checkbox"/>	<input type="checkbox"/>
Does patient have bleeding gums?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient ever had mouth or lip sores, which were slow to heal?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient worried about orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient dissatisfied with appearance of teeth or other facial structure?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient extremely sensitive regarding statements concerning facial/teeth anatomy or appearance? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has patient had previous orthodontic treatment or consult?	<input type="checkbox"/>	<input type="checkbox"/>
Has either parent had orthodontic treatment? Were extractions necessary?	<input type="checkbox"/>	<input type="checkbox"/>
Is patient adopted?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware that not all appointments can be made after school/work hours?	<input type="checkbox"/>	<input type="checkbox"/>
When did you become aware of the orthodontic problem? _____		
What are your primary concerns? _____		
Last general dental cleaning date (mo./yr.): _____ Last general/dental exam date (mo./yr.): _____		
Dental work pending? Write "None" or Describe: _____		

PATIENT (adult) or PARENT's SIGNATURE _____ DATE _____

Doctor's notes:
