Kifer Dental Specialist

1298 Kifer Road Ste# 506
Sunnyvale, CA 94086
408-735-7445

Patient Information Form - *Orthodontics*

Patient Name: _____ Nickname:_____ Sex: M/F DOB:_____
Address: _____ City: _____ State: ___ Zip:_____
Home Phone: _____ Work or Cell Phone:_____
Referred By: _____ Patient's Dentist: _____
Dentist's City:_____ Dentist's Phone Number: _____
Employer: _____ Social Security Number: _____
Insurance Company: _____ Group Number: _____
Spouse's Name: _____ Occupation: _____
Employer: _____ Social Security Number: _____
Insurance Company: _____ Group Number: _____ DOB: _____
Email Contact: _____
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Chief Complaint or Reason for seeking Orthodontics: _____
_____

Medical History

Allergy	Yes	No	Fainting/Dizziness	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Heart Disorders	Yes	No	Stomach Disorders	Yes	No
Bone Disorders	Yes	No	Heart Murmur	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No	HIV or AIDs	Yes	No
Epilepsy	Yes	No	Pneumonia	Yes	No	Others	Yes	No

Are you currently under a physician's care? Yes No
If yes, please explain _____
List Any Medications Being Taken _____
Have your tonsils or adenoids been removed? Yes No If yes, at what age? _____

Dental History

Date of last dental exam: _____

Do you grind or clench your teeth?	Yes	No
Does your jaw "click, crack or pop" upon opening or closing?	Yes	No
Does your jaw ever "lock" upon opening or closing?	Yes	No
Is there any pain from opening or closing your mouth?	Yes	No
Do you have TMD?	Yes	No
Have there been any injuries to the face, mouth or teeth?	Yes	No
Have you had any orthodontics treatment before?	Yes	No

If Yes, reason for treatment: _____

I agree to be completely responsible for this account regardless of insurance or marital status.

Patient's Signature: _____ Date: _____

Denise M. Doan D.D.S., M.M.Sc.
Orthodontics