

Sohail I. Simjee, D.M.D., Inc.  
Practice Limited to Orthodontics

Account # \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**I. PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_M\_\_\_F  
Last First Initial  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Street  
Home Phone (\_\_\_\_) - \_\_\_\_\_ Work Phone (\_\_\_\_) - \_\_\_\_\_  
Employer's name \_\_\_\_\_ Address \_\_\_\_\_  
Patient's General Dentist \_\_\_\_\_ Physician \_\_\_\_\_  
Patient's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_ Martial Status \_\_\_\_\_

**II. BILLING INFORMATION (If different Than above)**

Responsible Party: Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First Initial  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Street Apt #  
Phone (\_\_\_\_) - \_\_\_\_\_ (\_\_\_\_) - \_\_\_\_\_ May we contact you at Work \_\_\_Yes\_\_\_ No  
Birth date \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
Month/Date/Year Name Address  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_

**III. INSURANCE INFORMATION - Do You Have ORTHODONTIC insurance? \_\_\_Yes\_\_\_ No**

Do you have two insurance carriers? Yes \_\_\_No\_\_\_

**PRIMARY COVERAGE:**

Employee Name \_\_\_\_\_  
Last First Initial  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Employer: \_\_\_\_\_  
Name of Ins. Co. \_\_\_\_\_  
Union Local \_\_\_\_\_ Group \_\_\_\_\_

**SECONDARY COVERAGE:**

Employee Name \_\_\_\_\_  
Last First Initial  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Employer: \_\_\_\_\_  
Name of Ins. Co. \_\_\_\_\_  
Union Local \_\_\_\_\_ Group \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO DENTIST** - I hereby authorize payment directly to the below named dentist of the Group Insurance Benefits otherwise payable to me.

\_\_\_\_\_  
Insured's Signature Date \_\_\_\_\_

PLEASE COMPLETE OTHER SIDE OF THIS FORM



Patient's Name \_\_\_\_\_

Account # \_\_\_\_\_

1. Is patient in good health?  Yes  No  
If No, explain: \_\_\_\_\_
2. Is patient under physician's care now?  Yes  No  
If Yes, explain: \_\_\_\_\_
3. Is patient taking any medications?  Yes  No  
If Yes, name of medications: \_\_\_\_\_
4. Is patient taking any substances?  Yes  No  
If Yes, name of substance: \_\_\_\_\_
5. Have you taken the prescription drugs fenfluramine, fenfluramine combined with phen-termine (fen-phen), dexfenfluramine (redux), or other weight loss products?  Yes  No
6. Has patient ever had a blood transfusion?  Yes  No  
If Yes, explain: \_\_\_\_\_
7. Is patient pregnant or suspect?  Yes  No  
If Yes, how many months? \_\_\_\_\_
8. Has patient had any of the illnesses listed below?
 

Aids/ARC	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Dizzy Spells	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Veneral Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____	
Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N		
9. Has patient ever had a reaction to local anesthetic?  Yes  No  
If Yes, explain: \_\_\_\_\_
10. Is patient allergic to any medication (like penicillin)?  Yes  No  
If Yes, Explain: \_\_\_\_\_
11. Is patient allergic to metal or latex.  Yes  No  
If Yes, Explain: \_\_\_\_\_
12. Does patient's jaw pop or click when chewing?  Yes  No
13. Any accidents involving the teeth?  Yes  No
14. Has Patient had any disease, condition or problem not listed above that we should know about?  Yes  No  
Is Yes, explain: \_\_\_\_\_

**PLEASE CHECK ANY HABITS:**

- |               |  |                 |  |
|---------------|--|-----------------|--|
| Nail biting   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lip biting      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thumb Sucking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Night Grinding  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pencil biting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other habits: | _____  |                 |  |

Name of Patient's Dentist \_\_\_\_\_ Last Dental Checkup \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_  
Patient (Parent or Guardian, if minor) Patient (Parent or Guardian, if minor)

Health History Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_  
Orthodontist

Review 6 Months By: \_\_\_\_\_ Date \_\_\_\_\_ Review 12 Months By: \_\_\_\_\_ Date \_\_\_\_\_

Review 18 Months By: \_\_\_\_\_ Date \_\_\_\_\_ Review 24 Months By: \_\_\_\_\_ Date \_\_\_\_\_