PENINSULA
ORTHODONTIC GROUP INC.
JAMES N. TSAU, DMD
www.RedwoodCitySmiles.com

Please bring the completed form to your appointment. Thank you!

Today's Date: _____

Patient Information

Patient Name: _____ Dentist: _____

Address: _____ Zip: _____

Telephone: _____ Cell: _____

Birthdate: _____ Age: _____ Sex: ☐ Male ☐ Female

School/Employer: _____ Grade/Position: _____

Email: _____

Reason(s) for orthodontic consultation: _____

Primary

Responsible Party: _____ Telephone: _____

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

☐ Single ☐ Married ☐ Divorced

Address: _____ Zip: _____

Employer: _____ Telephone: _____

Social Security Number: _____ Birthdate: _____

Secondary

Responsible Party: _____ Telephone: _____

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

☐ Single ☐ Married ☐ Divorced

Address: _____ Zip: _____

Employer: _____ Telephone: _____

Social Security Number: _____ Birthdate: _____

How did you hear about us? *(Please check all that apply)*

☐ Referral: ☐ Dentist ☐ Patient ☐ Other _____

Name of person we may thank for the referral: _____

☐ Community Event: _____ ☐ Sporting Event: _____ ☐ School Event: _____

☐ Online ☐ Print Ad: (Where?) _____

☐ Other family members seen by us: _____

☐ Has the patient had a previous orthodontic evaluation? _____

Orthodontist reviewed medical history: _____

Date: _____

HEALTH HISTORY *(Check Yes or No for which the patient has had a history)*

AIDS	☐ Y ☐ N	Chest Pains	☐ Y ☐ N	Headaches	☐ Y ☐ N	Painful Chewing	☐ Y ☐ N
Allergic to Latex	☐ Y ☐ N	Chronic Neck Pain	☐ Y ☐ N	Heart Condition	☐ Y ☐ N	Periodontal Problems	☐ Y ☐ N
Anemia	☐ Y ☐ N	Clicking of Jaw	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Pregnant	☐ Y ☐ N
Arthritis	☐ Y ☐ N	Cold Sores/Herpes	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Prolonged Bleeding	☐ Y ☐ N
Asthma	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Seizures	☐ Y ☐ N
Bone Disorders	☐ Y ☐ N	Drug Allergies	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Speech Problems	☐ Y ☐ N
Bulimia	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Mouth Breathing	☐ Y ☐ N	TMJ Problems	☐ Y ☐ N
Cancer	☐ Y ☐ N	Fainting, Dizziness	☐ Y ☐ N	Muscular Disorders	☐ Y ☐ N	Tooth Grinding	☐ Y ☐ N
Cerebral Palsy	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Organ Transplant	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N

Any disease, problem or allergy not mentioned above? _____

Current medications? _____

Physician Name: _____ Telephone: _____

Any face, mouth or tooth injuries? _____

INSURANCE INFORMATION

Name of Primary Dental Insurance: _____

Employer: _____

Name of Policy Holder: _____

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Group #: _____ Member ID #: _____

Primary Holder's Date of Birth: _____

Name of Secondary Dental Insurance: _____

Employer: _____

Name of Policy Holder: _____

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Group #: _____ Member ID #: _____

Secondary Holder's Date of Birth: _____

Emergency Contact Name: _____

Address: _____

Daytime Telephone: _____ Evening Telephone: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes the medical status. I authorize the dental staff to perform the necessary dental services the patient may need. I also acknowledge that I have received a copy of the Notice of Privacy Practices (from the website or from the welcome packet in the mail). This office reserves the right to verify the credit status of potential patients or responsible party/guardian of patients 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 and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature: _____ Relationship to patient: _____ Date: _____

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