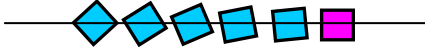


Kenneth A. Shimizu, DDS, MSD



Orthodontic Specialist for Children and Adults

Please fill out this form as completely as possible prior to your
Initial Orthodontic Examination Appointment

About You

Today's Date _____

Name _____ Please Circle: Mr Mrs Ms Dr

I prefer to be called _____ Birthdate _____ Age _____

Soc. Sec. # _____ Driver's License # _____

Home Address _____ Apt. # _____

Years at this address _____

Single Married Divorced Widowed Separated

Home # _____ Work # _____ e-mail _____

Employer _____ Years Employed _____ Occupation _____

Whom may we Thank for referring you to our office? _____

Other family members seen by us _____

Who will be financially responsible for your treatment? _____

Spouse Information

His/Her Name _____ Please Circle: Mr Mrs Ms Dr

Address (if different from above) _____

Soc. Sec. # _____ Driver's License # _____ Birthdate _____

Employer _____ Years Employed _____ Occupation _____

Home # _____ Work # _____ e-mail _____

Orthodontic Insurance

Is Orthodontic Coverage Available? Yes No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Group # _____

Is Secondary or Dual Insurance Coverage Available? Yes No

Name of Insured _____ Relationship _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____ Group # _____

Medical Information

Physician's Name _____ Date of Last Medical Exam _____

Address _____ Phone # _____

If currently under a Physician's care, for what reasons? _____

If taking any medications, please list: _____

Are you allergic to any medications: _____ Latex allergy? _____

Do you require any medications prior to dental work? _____

Women: if pregnant, how far along are you? _____

Do you have or have you ever had any of the following: (check if "Yes")

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Tuberculosis / Lung disease | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis / Liver Problems | <input type="checkbox"/> Cancer or Leukemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> H.I.V. Positive | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Growth Disorders |

If Yes, please explain _____

Dental Information

Current Dentist's Name _____ City _____ Date of Last Visit _____

Date of Last X-Rays _____ Type _____ Are you currently experiencing dental pain? _____

Have you had or do you notice any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Teeth sensitive to hot, cold, sweets or pressure | <input type="checkbox"/> Clicking or popping of jaw joint | <input type="checkbox"/> Pain, swelling, or bleeding gums |
| <input type="checkbox"/> Traumatic injury to teeth or mouth | <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Loosening of the teeth |
| <input type="checkbox"/> Pain or tenderness around ear, joint, or side of face | <input type="checkbox"/> Periodontal treatment | Oral habits: <input type="checkbox"/> Thumb or finger sucking |
| Difficulty in: <input type="checkbox"/> Opening / closing <input type="checkbox"/> Chewing | <input type="checkbox"/> TMJ / Splint treatment | <input type="checkbox"/> Lip / Cheek biting <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Swallowing <input type="checkbox"/> Speaking | <input type="checkbox"/> Ulcers / Cold sores | <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Tongue thrust |

If Yes, please explain _____

Are you nervous about having dental treatment? _____

Orthodontic Information

What is your primary concern about your teeth? _____

How would you like us to correct the problem? _____

Do you have any concerns about orthodontic treatment? _____

Have you had other Orthodontic consultations / treatment? _____ Orthodontist _____

Please describe _____

Have other family members had orthodontic treatment? _____ Orthodontist _____

Is there any additional information you would like us to know? _____

Please bring this completed form to your Initial Orthodontic Exam Appointment. We look forward to meeting you!

Signed _____ Date _____ Reviewed by _____

The information provided above may be used to obtain Insurance confirmation