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Orthodontics for Children and Adults-Invisalign*

Today's Date: _____
Patient's Name: _____ Age: _____ Sex: _____ Birthdate: _____
Address: _____ City: _____ Zip: _____ Phone: _____
Employer: _____ Address: _____ Phone: _____
Social Security #: _____ Marital Status: Single Separated Married Divorced
Spouse's Name: _____ Occupation: _____ Social Security #: _____
Person Responsible for Account (Full Name): _____
Social Security #: _____ Driver's License #: _____
Address (if different from patient): _____
Employer: _____ Address: _____ Phone: _____
Who referred you to this office? _____
Who noticed the orthodontic problem? Patient Dentist
Patient's Dentist: _____ Physician: _____
Date last dental visit: _____ Has dentist removed any teeth? _____
Describe the orthodontic problem in your own words: _____

Would patient mind wearing "braces" if necessary?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Is patient under a doctor's care or taking medication?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does Patient have a health problem now?	<input type="checkbox"/>	<input type="checkbox"/>	History of heart trouble, rheumatic fever, diabetes, bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
History of injury - to face, head or teeth?	<input type="checkbox"/>	<input type="checkbox"/>	History of ear infection, sore throats, frequent colds, asthma, allergies	<input type="checkbox"/>	<input type="checkbox"/>
History of mouth breathing, finger or thumb sucking, nail biting?	<input type="checkbox"/>	<input type="checkbox"/>	Have tonsils and adenoids been removed?	<input type="checkbox"/>	<input type="checkbox"/>
Has patient had a previous orthodontic examination? Date: _____ Dentist: _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever tested positive for HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
Any history of arthritis in the family?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth? (At night <input type="checkbox"/> During the day <input type="checkbox"/>)	<input type="checkbox"/>	<input type="checkbox"/>
Any "clicking" or soreness in the jaw area? (TMJ)	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware that success of treatment is dependent on the patients cooperation?	<input type="checkbox"/>	<input type="checkbox"/>
Any comments or questions? _____ _____ _____					

Does patient have orthodontic insurance? _____ (if so, complete this section) _____
Name of Insured: _____ Relationship to Patient: _____
Group Name and Number: _____ Policy Number: _____
Insurance Company: _____
Second Insurance Company: _____

* After you have verified orthodontic coverage with your insurance company, bring your signed form to us for processing. There will be a nominal fee for filing your claim. Filing orthodontic insurance claim forms is not necessary until treatment has begun.