

RAYMOND M. SUGIYAMA, D.D.S., M.S., Inc.
Orthodontics for Children and Adults

Today's Date _____

Patient's Name _____ Age _____ Sex _____ Birthdate _____

Address _____ City _____ Zip _____ Phone _____

Employer _____ Address _____ Phone _____

Social Security No. _____ Marital Status: Single Separated Married Divorced

Spouse's Name _____ Occupation _____ Social Security No. _____

Person Responsible for Account (Full Name) _____

Social Security No. _____ Driver's License No. _____

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	NO	Is patient under a doctor's care or taking medication?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<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, requent 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?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever tested positive for HIV Virus?	<input type="checkbox"/>	<input type="checkbox"/>
Date _____ Dentist _____			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 history of arthritis in the family?	<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 "clicking" or soreness in the jaw area? (TMJ)	<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 Co. _____

* 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.