HILLSIDE VIEW ORTHODONTICS
BY IKEDA + RIGHELLIS

2220 Mountain Blvd Ste 204 Oakland, CA 94611 | HillsideViewOrtho.com | 510.482.0600

PATIENT INFORMATION (ADULT)

Patient Legal Name _____ (First) _____ (Middle Initial) _____ (Last) Gender _____

Preferred Name (Nickname) _____ Birthdate _____ Pronouns _____

Home Address _____ Email _____

City _____ State _____ Zip _____ Cell Phone _____

Occupation _____

Employer _____

Has any other member member of the family been a patient at this office? Yes ☐ No ☐

Names: _____

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

In case of emergency, whom should we contact? _____ Relationship _____

Phone _____

PRIMARY DENTAL INSURANCE

Subscriber Legal Name _____ (First) _____ (Middle) _____ (Last) Same as Above ☐

Relationship to Patient _____ Subscriber Birthdate _____

Address _____ City _____ State _____ Zip _____

Subscriber Employed by _____

Insurance Company _____ State _____

Subscriber ID _____ OR Social Sec No _____ Group No _____

ADDITIONAL DENTAL INSURANCE

Subscriber Legal Name _____ (First) _____ (Middle) _____ (Last) Same as Above ☐

Relationship to Patient _____ Subscriber Birthdate _____

Address _____ City _____ State _____ Zip _____

Subscriber Employed by _____

Insurance Company _____ State _____

Subscriber ID _____ OR Social Sec No _____ Group No _____

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Patient Name _____ Date _____

Update _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Please Check Yes or No (If 'Yes,' please fill in details)

Are you taking any medication? _____ Yes☐ No☐
Has your physician advised prophylactic antibiotics for dental procedures? _____ Yes☐ No☐
Are you allergic to any medication, food or nickel/latex? _____ Yes☐ No☐
Have you had your tonsils/adenoids removed? If so what age: _____ Yes☐ No☐
Do you have a history of major illness/operations? _____ Yes☐ No☐
Have you ever been involved in a serious accident? _____ Yes☐ No☐
Are you pregnant? (Female only) _____ Yes☐ No☐
Any medical conditions we have not discussed that you feel we should be aware of? _____ Yes☐ No☐

Check any of the medical conditions below that you have had or currently have:

☐	Abnormal Bleeding	☐	Bone Disorders	☐	Heart Problems	☐	Pneumonia
☐	ADHD	☐	Diabetes	☐	Hepatitis/Liver Problems	☐	Radiation/Chemotherapy
☐	Anemia	☐	Dizziness/Fainting	☐	Herpes	☐	Sinus Problems
☐	Arthritis/Rheumatism	☐	Emotional Problems	☐	High Blood Pressure	☐	Thyroid Problems
☐	Asthma	☐	Epilepsy	☐	HIV/AIDS	☐	Tuberculosis
☐	Bisphosphonate Therapy	☐	Gastrointestinal Disorders	☐	Kidney Problems	☐	Tumor or Cancer
☐	Blood Disorders	☐	Hay Fever	☐	Nervous System Disorders	☐	

DENTAL HISTORY

Family Dentist _____ Date of Last Cleaning _____

Please Check Yes or No (If 'Yes,' please fill in details)

Are you currently seeing dental specialists (Periodontist, Oral Surgeon, Endodontist)? _____ Yes☐ No☐
Have you experienced any unfavorable reaction to dentistry? _____ Yes☐ No☐
Have there been injuries to your face, mouth, or teeth? _____ Yes☐ No☐
Do you have pain or clicking when opening/closing the mouth? _____ Yes☐ No☐
Has your jaw ever locked open or closed? _____ Yes☐ No☐
Do you have speech difficulties? _____ Yes☐ No☐
Do you have difficulty breathing through the nose? _____ Yes☐ No☐
Have you consulted with an orthodontist? If yes, please provide name/date: _____ Yes☐ No☐
Have you ever had orthodontic treatment? If yes, please provide name/date: _____ Yes☐ No☐

Check any of the dental conditions below that you have had or currently have:

☐	Bleeding Gums	☐	Cavity Prone	☐	Difficulty Losing Baby Teeth	☐	Missing Teeth
☐	Blisters on Lips/in Mouth	☐	Chewing Difficulties	☐	Extra Teeth	☐	Thumb/Finger Habits
☐	Broken/Chipped Teeth	☐	Clenching/Grinding Teeth	☐	Frequent Headaches	☐	Tongue Habits

What about your teeth/bite would you like to improve? _____

What concerns you most about orthodontic treatment?

☐ Appearance ☐ Cost ☐ Length of Time ☐ Pain ☐ Effectiveness ☐ Other _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC, and ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any change in my medical status. I authorize the Orthodontist and dental staff to perform the necessary dental/orthodontic services I may need.

Signature _____ Date _____