HILLSIDE VIEW ORTHODONTICS
BY IKEDA + RIGHELLIS
2220 Mountain Blvd Ste 204 Oakland, CA 94611 | HillsideViewOrtho.com | 510.482.0600

PATIENT INFORMATION (CHILD)

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

Preferred Name (Nickname) _____ Pronouns _____

Home Address _____ Birthdate _____

City _____ State _____ Zip _____

Name of School _____ Grade Level _____

Siblings (Ages) _____

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

PARENT(S) / GUARDIAN(S)

☐ Single ☐ Married ☐ Partners ☐ Divorced ☐ Widowed

Legal Name _____

Relationship _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____

Email _____

Occupation _____

Employer _____

Legal Name _____

Relationship _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____

Email _____

Occupation _____

Employer _____

Does family reside in same household? If no, what percentage in each home: _____ Yes ☐ No ☐

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

In case of emergency, whom should we contact? _____ (Name, Relationship) Phone _____

PRIMARY DENTAL INSURANCE

Subscriber Legal Name _____ 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 _____ 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)

Is the patient adopted? _____ Yes☐ No☐
Is the patient taking any medication? _____ Yes☐ No☐
Has the patient's physician advised prophylactic antibiotics for dental procedures? _____ Yes☐ No☐
Is the patient allergic to any medication, food or nickel/latex? _____ Yes☐ No☐
Has the patient had their tonsils/adenoids removed? If so what age: _____ Yes☐ No☐
Does the patient have a history of major illness? _____ Yes☐ No☐
Has the patient had any major operations? _____ Yes☐ No☐
Has the patient ever been involved in a serious accident? _____ 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 the patient has had or currently has:

☐	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)

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

Check any of the dental conditions below that the patient has had or currently has:

☐	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 the teeth/bite would you or your child like to improve? _____

What concerns you or your child 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 _____