Anton J. Bisbas, D.D.S.
ORTHODONTICS

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COMPLIMENTARY CONSULTATION

12750 Carmel Country Rd. Suite 202
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San Diego, CA 92109

## THIS APPOINTMENT IS FOR

Name: _____
Last First Middle
Nickname: _____ Male Female
Birthdate: _____/_____/_____ Age: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( _____ ) _____
Cell Phone: ( _____ ) _____
Hobbies/Sports/Musical Instruments: _____
_____
Did You visit our web site @ www.bisbasortho.com?
Yes No

## PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( _____ ) _____
Daytime Phone: ( _____ ) _____
Birthdate: _____/_____/_____ SS # _____
Employer: _____
Address: _____
City: _____ State: _____ Zip Code: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in medical status.

This office observes the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
Signature of Responsible Party

_____
Date

## INFORMATION IF A MINOR

**MOTHER'S NAME:** _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( _____ ) _____
Cell Phone: ( _____ ) _____
Birthdate: _____/_____/_____ SS # _____
Employer: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Daytime Phone: ( _____ ) _____

**FATHER'S NAME:** _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( _____ ) _____
Cell Phone: ( _____ ) _____
Birthdate: _____/_____/_____ SS # _____
Employer: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Daytime Phone: ( _____ ) _____

## PRIMARY DENTAL INSURANCE

Orthodontic Coverage: Yes No
Insurance Company: _____
Insurance Co. Phone: _____
Insurance Co. Address: _____
_____
Group # (Plan, Local, or Policy): _____
Primary Insured's Name: _____
Relationship to Patient: _____
Birthdate: _____/_____/_____ SS # _____
Policy Owner's Employer: _____
Other Coverage: Yes No

## SECONDARY DENTAL INSURANCE

Orthodontic Coverage: Yes No

Insurance Company: _____

Insurance Co. Phone: _____

Insurance Co. Address: _____

_____

Group # (Plan, Local, or Policy): _____

Secondary Insured's Name: _____

Relationship to Patient: _____

Birthdate: _____/_____/_____ SS # _____

Policy Owner's Employer: _____

## ADDITIONAL DENTAL INSURANCE

Orthodontic Coverage: Yes No

Insurance Company: _____

Insurance Co. Phone: _____

Insurance Co. Address: _____

_____

Group # (Plan, Local, or Policy): _____

Primary Insured's Name: _____

Relationship to Patient: _____

Birthdate: _____/_____/_____ SS # _____

Policy Owner's Employer: _____

## PERSONAL HABITS HISTORY

Are any of the following habits present?

| | | |
|---|---|---|
| Yes | No | Clenching/grinding teeth |
| Yes | No | Lip sucking/biting |
| Yes | No | Mouth breather |
| Yes | No | Nail biting |
| Yes | No | Smoking |
| Yes | No | Thumb/finger sucking |
| Yes | No | Tongue thrust |

Has puberty begun (boys) : Yes No
Has menstruation begun (girls) : Yes No

Physician_____

Please list other family members we have treated.

_____

_____

## DENTAL HISTORY OF PATIENT

What are the main concerns that you would like orthodontics to accomplish? _____

_____

_____

Have there been any injuries to the face, mouth, teeth, or chin? Yes No

Have adenoids or tonsils been removed? Yes No

Are there any missing or extra permanent teeth? Yes No

Is there any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No

Are there any speech problems? Yes No

Are teeth brushed on a daily basis? Yes No

Are teeth flossed on a daily basis? Yes No

Name of Dentist: _____

Date of Last Visit: _____/_____/_____

## MEDICAL HISTORY OF PATIENT

Have any of these conditions been present?

| | | |
|---|---|---|
| Yes | No | Abnormal bleeding |
| Yes | No | Allergic to latex/metals |
| Yes | No | Asthma |
| Yes | No | Cancer |
| Yes | No | Congenital heart defect |
| Yes | No | Convulsions/epilepsy |
| Yes | No | Diabetes |
| Yes | No | Handicaps/disabilities |
| Yes | No | Heart murmur |
| Yes | No | Hepatitis |
| Yes | No | HIV +/AIDS |
| Yes | No | Hospital stay/operations |
| Yes | No | Kidney/liver problems |
| Yes | No | Thyroid problems |

Please discuss any medical problems: _____

_____

_____

Please list any medications taken currently: _____

_____

Please list any known drug allergies: _____

_____

Please list any other allergies: _____

_____

Dr. Signature: _____