We Take Pride in Your Smile
Sarraf Orthodontics
5703 S. Vermont Ave.
Los Angeles, CA 90037
(323) 751-5600 Office
(323) 751-5611 Fax

PATIENT INFORMATION

PATIENT
Name__ _____
Address _____ Apt. #_____
City _____ Zip Code _____
How long at this address? _____
Telephone ( ) _____
Cell/Pager ( ) _____
E-mail _____
Social Security #_____ DL# _____
Age _____ Birthdate _____

Responsible Party (If same as above, please skip)
Name _____
Address _____ Apt. #_____
City _____ Zip Code _____
How long at this address? _____
Telephone ( ) _____
Cell/Pager ( ) _____
E-mail _____
Social Security #_____ DL# _____
Relationship to patient _____
Age _____ Birthdate _____

EMPLOYMENT
Occupation _____
Employer _____
How Long? _____
Business Address _____
City _____ Zip Code _____
Business Phone ( ) _____Ext. #_____
Verified By _____ Date _____

REFERENCES
Name _____
Address _____ Apt. #_____
City _____ Zip Code _____
Telephone ( ) _____
Name _____
Address _____ Apt. #_____
City _____ Zip Code _____
Telephone ( ) _____
Spouses Name _____
Spouse's Work # ( ) _____

PERSON TO CONTACT FOR EMERGENCY
Name _____
Address _____ Apt. #_____
City _____ Zip Code _____
Telephone ( ) _____

GETTING TO KNOW YOU
Are there other members of your household who are not patients at our office?
Yes ___ No ___ Please list names and relationship (son, daughter, husband):
1: _____ 2: _____
3: _____ 4: _____
How did you hear about our office?
Doctor's Referral _____ Doctor's Name:_____
Yellow Pages _____ Printed Material _____
Insurance Plan _____ Walk in Sign _____ Family or Friend _____
TV _____ Radio _____ Billboard _____ Website _____

INSURANCE
Primary Insurance
Name _____
Address _____
City _____ Zip code _____
Telephone ( ) _____
Employer _____
Union/local _____ Group #_____
Insurer's Name _____
Insured's Soc Sec No _____ Birthdate _____
Secondary Insurance
Name _____
Address _____
City _____ Zip Code _____
Telephone ( ) _____
Employer _____
Union/local _____ Group #_____
Insured's Name _____
Insured's Soc Sec # _____ Birthdate_____

MANAGED CARE PLAN (HMO)
Plan Name _____
Group #_____ Plan# _____
Employer _____
Insured's Name _____
Insured's Soc Sec # _____

1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that Sarraf Orthodontics provides business support services to independent dentists and recognize that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor Keivan Sarraf DDS, Inc or its subsidiaries is responsible for my dental treatment.

Signature _____ Date _____

We Take Pride in Your Smile
Sarraf Orthodontics

MEDICAL HISTORY		DENTAL HISTORY
Please check if patient has or had		Please check Yes or No
[Y] [N]	[Y] [N]	[Y] [N]
[ ] [ ] Joint Swelling	[ ] [ ] Tuberculosis	[ ] [ ] Any injuries to face, mouth, teeth? (circle)
[ ] [ ] Bone Disorders	[ ] [ ] Anemia	[ ] [ ] Thumb, finger, lip, object sucking? (circle)
[ ] [ ] Heart Trouble	[ ] [ ] Epilepsy (convulsions)	[ ] [ ] More than average amount of tooth decay?
[ ] [ ] Mitral Valve Relapse	[ ] [ ] Prolonged bleeding	[ ] [ ] Any missing permanent teeth?
[ ] [ ] Rheumatic Trouble	[ ] [ ] Faintness/Dizziness	[ ] [ ] Any extra permanent teeth?
[ ] [ ] Thyroid Problems	[ ] [ ] Tonsils removed	[ ] [ ] Any teeth removed by extraction?
[ ] [ ] Diabetes	[ ] [ ] Adenoids removed	[ ] [ ] Any difficulty in swallowing or chewing?
[ ] [ ] Emotional Problems	[ ] [ ] Sore throats	[ ] [ ] Any pain or clicking on opening mouth?
[ ] [ ] Brain Injury	[ ] [ ] Tonsillitis	[ ] [ ] Is patient adopted? At what age? _____
[ ] [ ] Kidney or Liver Problems	[ ] [ ] Earaches	[ ] [ ] Does patient visit dentist regularly? Date of last visit _____
[ ] [ ] Joint Prosthesis	[ ] [ ] Arthritis	[ ] [ ] Has an orthodontist consulted previously?
On items checked "Yes" please provide us with a more detailed description:_____		On items checked "Yes" please provide us with a more detailed description:
_____		_____
_____		_____
_____		_____

List any other serious illnesses: _____

List any allergies: _____

Is patient currently under physician's care? List reason. _____

_____

Name of physician: (Primary) _____ (Secondary) _____

Name of General Dentist: _____ Address: _____

Approximately how many inches has the patient grown in the last year? _____

What would you like orthodontic treatment to accomplish? _____

Patient's attitude towards treatment: Circle one (Very motivated) (Will cooperate if needed) (Not motivated)

Adolescent Females: Has menstruation begun? [ ] Yes [ ] No Date (month/year) _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics.

Patient signature or parent if patient is a minor _____ Date _____

Doctor Signature _____ Date _____

Recall Review:

1. Patient Signature _____ Doctor Signature_____ Date _____

2. Patient Signature _____ Doctor Signature_____ Date _____

3. Patient Signature _____ Doctor Signature_____ Date _____