Kenneth Irigoyen D.M.D., P.A. Orthodontist

Patient Information

Patient Information					А	В	С	
Date								
Patient's Name	Last		Firet	Middle				
Address			First	Middle				
Street		City	State	Zip			_	
Nickname	Birthdate	Age	Sex	Social Security #				
If patient is a minor, give parent or	guardians' name							
Whom may we thank for referring	you to our office?							
Responsible Party Informa	tion							
NameLast		First	Middle		Marita	l Status		
Residence	Street		City	State				
Mailing Address			City	State	Zip			
_	Street		City	State	Zip			
How long at this address?		Home Phone		Work Phone			—	
Previous Address (if less than 3 yr	·s)	Olympia	0"	Olyte	71.			
Social Security #		Street Birthdate	City	StateRelationship to Patient	Zip			
Employer								
		Occupation						
Spouse's Name	st F	First	Middle	Relationship to Patient				
Employer		Occupation		No. Years Employed				
Social Security #		Birthdate		Work Phone				
Insurance Information				O # #				
Insured's Name				-				
Insurance Company								
Insurance Co. Address			_ Phone				—	
Insured's Employer							—	
Do you have secondary coverage								
Insured's Name			_ Insured's Social Security #					
Insurance Company			_ Group Number_				_	
Insurance Co. Address			_ Phone					
Insured's Employer								

Emergenc	/ Information
Name of nearest relative not living with you	
Complete Address	
Phone Number	
<u> </u>	
I understand that where appropriate, credit bureau reports may	e obtained.
Signature (Parent's signature if minor)	
Update Signature	Update Signature
Date	Date

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Adult History

A	dult	History			
Pa	tient l	Name			
\/\/	at is	your chief concern for us at this visit?			
***	iat io	your office content for do at allo viole.			
		circle Y (yes) or N (no) for the following questions, whichever applies. or the question for additional explanations.	Your an	iswers	are for our records only and will be considered confidential. Please use the
Me	edica	al History			
Υ	Ν	Are you in excellent health?			
Υ	Ν	Has there been any change in your general health within	n the l	ast ye	ear?
Υ	Ν	My last physical exam was(month/year)			
Υ	Ν	Are you now under the care of a physician? If so, what i			ated?
Υ	N	Have you had a serious illness/hospitalization in the pass If so, for what?			
Υ	N	Are you taking any medication (incl. non-prescription)?			
Do					
		nave any of the following conditions? s or drug reactions to:			
Y		Latex	Υ	N	Abnormal bleeding or blood transfusion
Y	N	Penicillin or other antibiotics	Y	N	Low blood pressure
Y	N	Sulfa drugs	Y	N	Cardiovascular disease (heart trouble, attack,
Y	N	Aspirin, Ibuprofen, Tylenol	'	14	angina, high blood pressure, arteriosclerosis, stroke)
Y	N	Local anesthetics	Υ	N	Damaged or artificial heart valves, including
Y	N	Codeine or other narcotics	'	14	heart murmur or rheumatic heart disease
Y	N	Other	Υ	N	Arthritis or joint problems or artificial joints/limbs
Y	N	Respiratory problems, emphysema	Y	N	Require pre-medication before dental visits?
Y	N	Asthma or hay fever	Y	N	Birth Defects
Υ	N	Sinus trouble	Y	N	Kidney trouble
Υ	N	Persistent swollen neck glands	Y	N	Tuberculosis
Υ	N	Thyroid or endocrine problems	Υ	Ν	Bone fractures or trauma to face or jaw
Υ	N	Diabetes	Υ	Ν	Vision, hearing or speech difficulty
Υ	N	Hepatitis, jaundice or liver disease	Υ	Ν	Persistent Cough
Υ	Ν	AIDS or HIV infection	Υ	Ν	Frequent colds or sore throats
Υ	Ν	Sexually transmitted disease	Υ	Ν	
Υ	Ν	Substance abuse problem (past or present)	Υ	Ν	Stomach ulcer or hyperacidity
Υ	Ν	Mental health problem or nervous disorder	Υ	Ν	Tumor (Cancerous or benign)
Υ	Ν	Fainting spells or seizures	Υ	Ν	Radiation therapy or Chemotherapy
Υ	Ν	Epilepsy or other neurological disease	Υ	Ν	Females: Are you pregnant?
Υ	Ν	Fainting spells or seizures			
Υ	Ν	Blood disorder such as anemia			
Υ	Ν	Do you have any disease, condition or problem not liste	d abov	ve tha	at you think we should know about?
If o	o nio	ase explain			
11.5	o, pie	ase explain			

Y N Teeth Y N Jaw fr Y N Previo Y N Bleed Y N Other Y N Frequ Y N Mouth Y N Abnor Y N Have TMJ History Y N Have Y N Do yo Y N Hoo yo Y N Do yo Y N Has y Y N Does Patient Motir Patients often r checking the fo Teeth - If your fa Straig Straig Straig Move Move Move Show Reduc Make Symptoms - If	ped or injured permanent teeth in sensitive to hot or cold fractures, cyst, mouth infections ious root canal therapy ding gums or bad taste/mouth odor for periodontal (gum) problems lems with food trapped between teeth uent canker sores or cold sores th breathing habit or snoring troubles formal swallowing (tongue thrust) be you had a negative dental experience	ce? sual? ment es and relief from p fic (circle the word	Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	ate of NNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNNN	last dental exam History of missing or extra teeth Have any permanent teeth been Have wisdom teeth been remove Teeth that irritate tongue, cheek, Previous orthodontic treatment of Previous periodontal (gum) treat Numerous fillings Damaged restorations or fillings Thumb or finger habit as a child Loose or shifting teeth Is all dental work completed at the Do you have pain in your jaw join Do you experience soreness in to of your face or around ears? Do you notice clicking or popping jaw joint? Do you have difficulty chewing o	n removed? ed? , lip, etc. or retainer tment his time? nt? the muscles
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symptoms - If	e upper teeth — forward / backward e lower teeth — forward / backward facial appearance could be changed, e upper lip — forward / backward e lower lip — forward / backward w — more / less — of my teeth when w — more / less — of my gums when uce the strain in my — chin / lips — w e my lips — closer together / farther	what would you c I smile I smile when I close my lip	Otl change? Ma Ge Mo Mo Ss Otl	her_ ake m et rid o ove ch ove ch her_		
☐ In fror	f you want to reduce pain or discomfo	ort. please be spec	cific abo	ut its	location: circle the right or left side	or both if they apply
	ont of ears — right / left	☐ My temples —			☐ My jaw joints — ri	
■ Below	w ears — right / left	☐ My eyes — rig			☐ My teeth	
	ve ears — right / left	☐ My neck — rig			☐ My sinuses	
☐ In my	y ears — right / left	☐ My shoulders	- right	/ left		
een answered t	nave read and understand the above. I a to my satisfaction. I will not hold my den npletion of this form. If there is any chang	tist or any other mer	mber of h	is/her	r staff responsible for any errors or om edical or dental status, I will inform the	issions that I may have
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