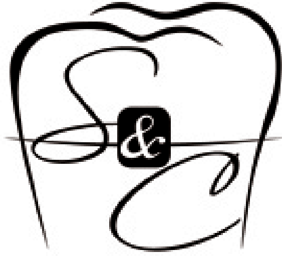


Sanchez & Craig Orthodontics

**WELCOME TO THE OFFICE OF ANNE T. SANCHEZ, D.M.D.
& NOELL CRAIG, D.M.D.**

Name ______________________________ Date of Birth ______________

Name You Prefer to be Called ______________________________

Age ______________ Sex: Male _____ Female _____ Telephone ______________

Home Address ______________________________ Zip ______________

Marital Status M _____ S _____ D _____ SS# ______________________________

Occupation ______________________ Employer ______________________

Business Address ______________________________ Telephone ______________

Spouse's Name ______________________________

Occupation ______________________ Employer ______________________

Business Address ______________________________ Telephone ______________

Other Family Members Treated in Our Practice ______________________________

Whom may we thank for referring you? ______________________________

Orthodontic Insurance Yes _____ No _____ Carrier ______________________________

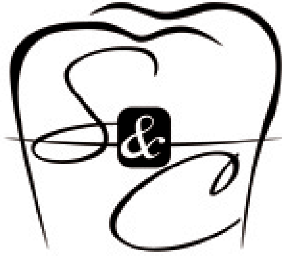
SS# of Insured ______________________________ DOB of Insured ______________

MEDICAL AND DENTAL HISTORY

Dentist ______________________________

Date of Last Appointment ______________________________

Has an orthodontist been consulted previously? ______ When? ______________________



Sanchez & Craig Orthodontics

Patient's Physician ______________________________ Phone ____________________

Are you in good health? _____ Yes _____ No _____ History of Major Illness? ____________________

Are you currently under the care of a physician? __________ Yes __________ No

If so, explain ____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

_____ Pre-medication for any medical/dental procedure

_____ Bleeding problems	_____ Emotional problems	_____ Arthritis	_____ Kidney
_____ Endocrine problems	_____ Glaucoma	_____ High blood pressure	_____ Epilepsy
_____ Liver disease	_____ Venereal disease	_____ Allergies/Asthma	_____ Hepatitis
_____ Rheumatic fever	_____ Endocrine problems	_____ Bone disorder	_____ Diabetes
_____ Jaw joint pain TMJ	_____ Night grinding of teeth	_____ AIDS	

List any medications you are taking ______________________________________

Have you ever had gum disease? ______________________________________

Have you been informed about missing or extra teeth? ______________________________

Reasons for seeking orthodontic treatment ______________________________

____

Please list any additional information which you feel is helpful ______________________

____

Thank you.

____
Signature