# Dr. Juan R. Emmanuel Jr.
# Dr. Charles H. Quiles
# Orthodontics

Birthdate: ______________

Patient's Name: __________________________________________ Age: ______ Gender: ______

Mailing Address: ________________________________________________________________________________

Residential address: ______________________________________________________________________________

Cell #: _____________________ Residential #: ________________________ Work #: ______________________

Email: _____________________ Place of employment or school where you study: ___________________________

Position held: ___________________________ Time in employment: _____________________

# Social Security: _____________________________ Driver’s license #: ________________________

Do you have Orthodontic Insurance? ___________ Name of insurance company: __________________________

Patient Dentist: Dr. _________________________ Referred By: ___________________________________

When was you last dental appointment? _________________________________________

Major reason you schedule visit today? ____________________________________________________________

**Information for Parents of minors and Spouse for adults**

Name of Parent (spouse / adults): _____________________________ Social Security: ________________

Date of Birth: __________________________ Driver's License _________________________

# of Dependents _______ E-mail: _____________________________________________________

Cell #:___ _________________ Residential: ________________________ Work: ______________________

Place of employment: ____________________________ Position: ______________ Time at job: _____________

Mailing Address: _______________________________________________________________________

Residential address: _____________________________________________________________________

Income: Weekly $ ____________ Biweekly $ _____________ Monthly $ _______________

Mother's Name (spouse / adult): ___________________ Social Security: _____________________

Date of Birth: _______________________________ Driver's License #: ________________

E-mail: __________________________ Phone: Cell: ___________________ Work: _______________________

Place of employment: ___________________ Position: ________________________ Time: ___________

Mailing Address: _______________________________________________________________________

Residential address: _____________________________________________________________________

Income: Weekly $ ____________ Biweekly $ _____________ Monthly $ _______________

Person Responsible for the Account: ________________________________________________________

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Social Security Number ______________________ License # _________________________________

Name of Primary Physician: Dr. __________________________ Phone: ___________________________

Is the patient in good health? ______, if not explain: ___________________________________________

Are you currently under any medical treatment? ______

Explain if your answer is yes. ______________________________________________________________

__________________________________________________________________________________________

Are you currently taking any medications? ______ if yes list below.

Names of drugs you are currently taking: _______________________________________________________

__________________________________________________________________________________________

List any disease or condition you currently have: ________________________________________________

__________________________________________________________________________________________

Check the appropriate box if you have any of the following conditions:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High blood pressure | ☐ Yes | ☐ No | Heart murmur | ☐ Yes | ☐ No | Pregnant | ☐ Yes | ☐ No |
| Heart problems | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Venereas | ☐ Yes | ☐ No |
| Rheumatic fever | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No |
| Bone problems | ☐ Yes | ☐ No | HIV positive | ☐ Yes | ☐ No | Sinusitis | ☐ Yes | ☐ No |
| Ear problems | ☐ Yes | ☐ No | Accidents | ☐ Yes | ☐ No | Mononucleosis | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No | Headache | ☐ Yes | ☐ No | Arthritis | ☐ Yes | ☐ No |

Other (Specify): ______________________________________________________________________

Is there a history of allergy to medications, foods, or others? ________ if yes please list below.

If yes, please specify: _____________________________________________________

| | | | | | |
|---|---|---|---|---|---|
| Have you been hit in the face? | ☐ Yes | ☐ No | Do you or have you sucked your thumb? | ☐ Yes | ☐ No |
| Have you ever been hit in the teeth? | ☐ Yes | ☐ No | Do you have problems with speaking? | ☐ Yes | ☐ No |
| Do you breathe through your mouth? | ☐ Yes | ☐ No | Have you had many cavities? | ☐ Yes | ☐ No |
| Have you seen another orthodontists? | ☐ Yes | ☐ No | Have you seen an oral surgeon? | ☐ Yes | ☐ No |
| Do your jaws get tired? | ☐ Yes | ☐ No | Does your mouth make a sound when opening? | ☐ Yes | ☐ No |
| Do you have pain in the jaw? | ☐ Yes | ☐ No | Do your gums bleed? | ☐ Yes | ☐ No |

Please comment on the back of this page, any medical or dental conditions not mentioned here.

I certify that all information provided today is correct

Signature ____________________________________________ Date _______________