Ahwatukee Office
16611 S 40th St
Suite 110
Phoenix, AZ 85048

Saperstein ORTHODONTICS

Glendale Office
5750 W Thunderbird Rd
Suite H-800
Glendale, AZ 85306

www.saportho.com
info@saportho.com
602-978-2100

ABOUT YOU

Today's Date: _____

Name: _____
☐ Mr ☐ Mrs ☐ Ms ☐ Dr
Preferred Name: _____
Birthdate: ___ / ___ /___ Age: _____ ☐ M ☐ F
Home Address: _____
City/State/Zip: _____
Home # _____ SSN: _____
Cell # _____ Carrier: _____
Email: _____
Employer: _____ Occupation: _____
Work #: _____ Ext: _____ How long at job?__
Work Address: _____
City/State/Zip: _____
Hobbies/Interests: _____

Has anyone else in your family had orthodontic treatment?
_____

Whom may we thank for referring you to our office?
_____

SPOUSE'S INFORMATION

Spouse's Name: _____
☐ Mr ☐ Mrs ☐ Ms ☐ Dr
Employer: _____ Occupation: _____
Work #: _____ Ext: _____ How long at job?__
Work Address: _____
City/State/Zip: _____
Birthdate: ____ / ____ / ____ SSN: _____
Preferred Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Phone # _____
Name: _____
Phone # _____

DENTAL INSURANCE

PRIMARY
Insurance Co Name: _____
Insurance Co Address: _____
Insurance Co Phone #: _____
Group # (Plane, Local, or Policy #): _____
Policy Holder's Name: _____ Relation: _____
Birthdate: ___ /___ /___ Employer: _____
SSN: _____ Ins. ID _____
Orthodontic coverage ☐ Y ☐ N

SECONDARY
Insurance Co Name: _____
Insurance Co Address: _____
Insurance Co Phone #: _____
Group # (Plane, Local, or Policy #): _____
Policy Holder's Name: _____ Relation: _____
Birthdate: ___ /___ /___ Employer: _____
SSN: _____ Ins. ID _____
Orthodontic coverage ☐ Y ☐ N

FOR YOUR INFORMATION

Our office is committed to exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. Drs. Saperstein and their staff attend continuing education seminars in order to stay on the cutting edge of new developments in orthodontics. Both Dr Elliot and Dr Vina are board certified orthodontists in the state of Arizona.

MEDICAL HISTORY

Physician: _____
Phone #: _____ Last Visit: ___ /___ /___
Current physical health: ☐ Good ☐ Fair ☐ Poor
Currently under the care of a physician?
Please explain: _____
_____
_____

Are you currently taking any medications? ☐ Y ☐ N
Please list medications:_____
_____
_____

For Women: Are you currently pregnant?
☐ Y ☐ N Due Date: ___ /___ /___

Have you ever had any of the following?

- ☐ Cancer/Chemotherapy
- ☐ Tumor/Growth
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ HIV+/AIDS
- ☐ Heart Surgery/Pacemaker
- ☐ Congenital Heart Defect
- ☐ Mitral Valve Prolapse
- ☐ Artificial Joint
- ☐ Artificial Valves
- ☐ Sinus Problems
- ☐ High/Low Blood Pressure
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Thyroid Disease
- ☐ Heart Attack/Stroke
- ☐ Angina
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Psychiatric Concern
- ☐ Tuberculosis (TB)
- ☐ Hepatitis
- ☐ Head/Jaw Injury
- ☐ Hemophilia
- ☐ Ulcers/Colitis
- ☐ Anemia/Radiation
- ☐ Asthma
- ☐ Persistent Cough
- ☐ Arthritis
- ☐ Blood Transfusion
- ☐ Glaucoma
- ☐ Down Syndrome
- ☐ Autism
- ☐ Hospitalization

Please list any other serious medical conditions:
_____
_____

Are you allergic to any of the following:

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Cephalexin
- ☐ Anesthesia
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Epinephrine
- ☐ Sulfa

Please list any other allergies:
_____
_____

DENTAL HISTORY

Please describe your orthodontic concern(s):
_____
_____

Have you ever been evaluated for orthodontic treatment before? ☐ Y ☐ N

Current dental heath: ☐ Good ☐ Fair ☐ Poor

Satisfied with smile?	☐ Y ☐ N
Do you brush daily?	☐ Y ☐ N
Do you floss daily?	☐ Y ☐ N
Do your gums bleed?	☐ Y ☐ N
TMD pain?	☐ Y ☐ N

Current habits

Lip sucking/biting?	☐ Y ☐ N
Nail biting?	☐ Y ☐ N
Mouth breathing?	☐ Y ☐ N
Thumb sucking?	☐ Y ☐ N
Do you grind/clench?	☐ Y ☐ N

Current dentist: _____
Date of last visit: ___ /___ /___

CONSENT

By signing below, I hereby affirm that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. With my informed consent, I authorize the dental staff to perform and necessary dental services that I may need during diagnosis and treatment.

_____ ___ /___ /___
Signature Date

Please select one of the options below

- ☐ I will not require financial arrangements through your office
- ☐ I am interested in obtaining financial arrangements through your office