

# John M. Sparaga, D.M.D.

Temporomandibular Joint Disorders, Orofacial Orthopedics, Surgical Orthodontics.

PLEASE COMPLETE PRIOR TO INITIAL APPOINTMENT

Date \_\_\_\_\_ **ORTHODONTIC ACQUAINTANCE CARD** Patient# \_\_\_\_\_

**Please complete the following personal information and bring to your Initial Exam:**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Last, First and Middle Initial

Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation & Employer \_\_\_\_\_

State \_\_\_\_\_ Drivers License # or ID # \_\_\_\_\_ Social Security No. \_\_\_\_\_

*Patient's Dentist* \_\_\_\_\_ Physician \_\_\_\_\_ Oral Surgeon \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Have you seen our TV ad? Y/N Website? Y/N

## IF PATIENT IS MARRIED, COMPLETE THIS PORTION

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_

## IF PATIENT IS A MINOR (UNDER 18), COMPLETE THIS PORTION

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Bus. Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Social Security No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date Of Birth \_\_\_\_\_ Date Of Birth \_\_\_\_\_

License Number \_\_\_\_\_ License Number \_\_\_\_\_

## FINANCIAL INFORMATION

Person Responsible for Account \_\_\_\_\_ Relationship \_\_\_\_\_ Res/Bus Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Financial Institute (Alaska USA, Wells Fargo, etc.)  
\_\_\_\_\_

# HEALTH QUESTIONNAIRE

Please answer each question. Circle **Yes** or **No** where applicable.

## MEDICAL HISTORY

1. Is patient in good health?..... Yes No
  2. Is patient presently under the care of a physician?.....Yes No  
If yes, what condition is being treated? \_\_\_\_\_
  3. Has patient ever had any serious illness or operation?.....Yes No
  4. Is patient taking any drugs or medication?.....Yes No  
If yes, what? \_\_\_\_\_
  5. **Does patient have any allergies?**.....**Yes No**  
If yes, please list \_\_\_\_\_
  6. Does patient use tobacco products?.....Yes No  
If yes, please indicate type and frequency \_\_\_\_\_
  7. Does patient have tendency to colds, sore throats, ear infections?.....Yes No
  8. Has patient reached puberty?.....Yes No  
Menstruated (girls) age \_\_\_\_\_ or voice changed (boys) age \_\_\_\_\_
  9. Does patient have, or ever had any of the following: (Please circle known conditions)
- |                     |                                       |                            |                      |
|---------------------|---------------------------------------|----------------------------|----------------------|
| Anemia              | Blood Diseases                        | Rheumatism or Arthritis    | Epilepsy or Seizures |
| Heart Ailments      | Hepatitis, Jaundice, or Liver Disease | Head Injuries              | Mental Disorders     |
| High Blood Pressure | Kidney Disease                        | Stomach Ulcers             | Stroke               |
| Respiratory Disease | Tumors or Growths                     | Difficulty in Swallowing   | Glaucoma             |
| Tuberculosis        | Radiation Treatment of any kind       | Venereal Disease           | Herpes               |
| Nervous Disorders   | Allergies                             | Acquired Immune Deficiency | Sinus Trouble        |
| Diabetes            | Asthma or Hay Fever                   | Other _____                |                      |
| Excessive Bleeding  | Fainting Spells                       | _____                      |                      |
| Rheumatic Fever     | Artificial Prosthesis (Implants)      | _____                      |                      |
10. Does patient have any disease, condition, or problem not listed?.....Yes No  
If so, please explain: \_\_\_\_\_

## DENTAL HISTORY

1. **Date of last dental examination:** \_\_\_\_\_
2. **Is dental work complete?**.....**Yes No**
3. How often does patient brush teeth? \_\_\_\_\_ Floss? \_\_\_\_\_
4. Has patient ever had an injury to face or jaw?.....Yes No
5. Is patient aware of tooth grinding or clenching habits?.....Yes No
6. Does patient have any speech problems?.....Yes No
7. Does patient breathe mostly through the mouth, and/or are lips usually parted?.....Yes No
8. Has patient ever sucked a thumb or finger?.....Yes No  
If yes, until what age? \_\_\_\_\_
9. Does orthodontic/dental treatment make the patient nervous?.....Yes No  
If yes, circle: slightly moderate extremely
10. Does the patient's jaw make "clicking or popping" sounds while chewing?.....Yes No

### TERMS & CONDITIONS

As a condition of the patient's treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry orthodontic insurance understand that all orthodontic services furnished are charged directly to the person who is personally responsible for payment of orthodontic services. If requested, we will supply the billing party with a receipt/pre-authorization/itemized statement for orthodontic/temporomandibular joint initial examination/records treatment. This orthodontic office cannot render services on the assumption that our charges will be paid by an insurance company.

The undersigned understands that the fee estimate listed for this orthodontic case can only be extended for a period of 30 days from the date of the patient's examination. In consideration of the professional services rendered to the patient by the Doctor and/or his staff, the undersigned agrees to pay the value of said services to said Doctor, or his assignee, at the time said services are rendered, or within the agreed upon treatment fee schedule. Additionally, the undersigned agrees that once the treatment contract has been signed and the treatment officially begun, missed appointments or failure to show does not constitute a cancellation of services, and payments according to the payment schedule are due and payable until the account balance is paid off entirely. The undersigned further agrees to pay all costs and attorney fees associated with any and all cases on their behalf. The undersigned grants permission to Clear Smiles Alaska to telephone the patient or billing party at home or work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

**Signed:** \_\_\_\_\_

**Date** \_\_\_\_\_