southoc Orthodontics
Where smiles start.

Chris Carter, DMD, MS

26137 La Paz Road, Suite 220
Mission Viejo, CA 92691
949-581-5801 x2
southocorthodontics.com

Personal Information

Patients Name _____ Age _____

Address _____ City _____ Zip _____

Home Phone _____ Cell _____

Email _____

Birthdate _____ Social Security # _____

Employed By _____

Occupation _____

Spouses Name _____ Cell _____

Who may we thank for referring you? _____

Insurance Information

Person(s) Financially Responsible _____ Phone _____

Do you have dental insurance? _____ If Yes, Name of Insurance Company _____

If Different From Above: Insured Social Security # _____ Insured Birthdate _____

Medical History

Dentist _____ Physician _____ Oral Surgeon _____

☐YES ☐NO DIABETES	☐YES ☐NO ANEMIA	☐YES ☐NO PROLONGED BLEEDING
☐YES ☐NO PNEUMONIA	☐YES ☐NO EPILEPSY	☐YES ☐NO FAINTING/DIZZINESS
☐YES ☐NO HEART TROUBLE	☐YES ☐NO ASTHMA	☐YES ☐NO NERVOUS DISORDERS
☐YES ☐NO RHEUMATIC FEVER	☐YES ☐NO KIDNEY INVOLVEMENT	☐YES ☐NO LIVER INVOLVEMENT
☐YES ☐NO BONE DISORDERS	☐YES ☐NO TUBERCULOSIS	☐YES ☐NO ENDOCRINE PROBLEMS
☐YES ☐NO HEPATITIS	☐YES ☐NO GLAUCOMA	☐YES ☐NO HIV/AIDS

List any drugs or medications now being taken _____

History of Allergies or Drug Sensitivity _____ Have you ever taken Fosamax or similar drugs? _____

(FEMALES) Are you pregnant? _____ Are you presently taking birth control? _____

Dental History

Have there been any injuries to the face, mouth, or teeth? _____

Are you aware of having a mouth breathing habit? _____

Have you been informed of any missing or extra permanent teeth? _____

Have you had an orthodontic consultation before? _____ Have you had orthodontic treatment before? _____

If yes, when and where? _____

_____

Date of last dental examination _____

What would you most like to have orthodontic treatment accomplish? _____

_____

Signature _____ Date _____