Castle ORTHODONTICS
ERIC J. CASTLE, DMD, MS

1070 E Clark Ave
Santa Maria, CA
(805) 937-3003

PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Birthdate_____ _____

If patient is a minor, give parent's or guardian's name _____

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

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

Home phone_____ Work phone_____

Cell/other phone_____ Email address _____

Relationship to Patient_____

Employer_____ Occupation_____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____

Birthdate _____Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes, please complete the information below for the second insurance carrier.

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

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MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness or accident? _____
Yes No Have the tonsils and/or adenoids been removed? What age? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding	Diabetes	Hepatitis/Liver problems
Anemia	Prolonged Bleeding	Rheumatic Fever
Arthritis	Epilepsy	Tuberculosis
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids
Bone Disorders	Heart Problems	Kidney problems

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist's Name _____ Date of last cleaning _____
What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Are you aware of any missing permanent teeth? Which ones? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Do you have any type of thumb, tongue or other habit? _____
Yes No Are you a mouth breather? _____
Yes No Do you snore? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Do you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you had any previous orthodontic treatment? When and where? _____
Female Patients only:
Yes No Are you pregnant? _____

The above information is accurate to the best of my ability.

Signature: _____ Date: _____