



**AGAPE ORTHODONTICS**

愛加倍矯正診所

Cupertino

Fremont

Milpitas

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Cupertino, CA 95014  
Phone: 408-873-8321

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Phone: 510-792-5551

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Milpitas, CA 95035  
Phone: 408-935-9555

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## Patient Information

Name \_\_\_\_\_ Sex  M  F  
First Last Middle

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

Birthdate    /    /    Age    Email \_\_\_\_\_  
MM DD YYYY

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

General Dentist \_\_\_\_\_ Last Visited \_\_\_\_\_

Whom may we thank for referring you to our office \_\_\_\_\_

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## Spouse/Additional Contact Information

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
First Last Middle

Address \_\_\_\_\_  Same as above  
Street City State Zip

Birthdate    /    /    Email \_\_\_\_\_  
MM DD YYYY

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
999-999-9999 999-999-9999

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## Insurance Information

### PRIMARY

Policy Owner's Name \_\_\_\_\_ Policy Owner's Social Security # \_\_\_\_\_

Policy Owner's Birthdate    /    /    Relationship to Patient \_\_\_\_\_  
MM DD YYYY

Policy Owner's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No (plan, local, or policy) \_\_\_\_\_

Insurance Company's Address \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

Do you have dual coverage?  Y  N

## SECONDARY

Policy Owner's Name \_\_\_\_\_ Policy Owner's Social Security # \_\_\_\_\_

Policy Owner's Birthdate      /      /      Relationship to Patient \_\_\_\_\_  
MM DD YYYY

Policy Owner's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_

Insurance Company's Address \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

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## Medical History

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joint/Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure                | <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Automobile/Sports       | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV                                | <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Apnea         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Injury                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Hospitalization for Any Reason     | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke/Heart Attack |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer/Chemotherapy     | <input type="checkbox"/> Yes <input type="checkbox"/> No Loud Snoring                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problem     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Defects/Murmur    | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment                | <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco Use         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes Frequent       | <input type="checkbox"/> Yes <input type="checkbox"/> No Fomax/Bisphoshonate (Osteoporosis) | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis (TB)   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches Hepatitis     | <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in Your Ears/Earaches      | <input type="checkbox"/> Yes <input type="checkbox"/> No Others: _____       |

Any known Allergies: \_\_\_\_\_

Medication(s): \_\_\_\_\_

Any serious/difficult problem associated with any dental treatment before?  Yes  No

Any joint pain/clicking/problem (TMJ/TMD)?  Yes  No

Are you aware of teeth grinding at night/during the day?  Yes  No

Are you a mouth breather?  Yes  No

Any problem with dental restorations failures?  Yes  No

Have you had evaluation before?  Yes  No

If so, what question(s) do you have? \_\_\_\_\_

Rank order of importance of treatment (1 being the top priority) \_\_\_\_\_ Result \_\_\_\_\_ Service \_\_\_\_\_ Price

Main concern that you want to resolve by this treatment: \_\_\_\_\_

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form \_\_\_\_\_ Date \_\_\_\_\_