Dr. Lisa Kochis
ORTHODONTICS

Today's Date:_____

PATIENT INFORMATION

Name: _____ Nickname: _____Sex: M or F SS#_____
Address: _____ City, State, Zip: _____ Date of Birth: _____ Age: ___
Home Phone: _____ General Dentist: _____Last Visit: _____
Employer: _____ Work Phone:_____
Email:_____ Whom may we thank for this referral? _____
What is your chief orthodontic concern?_____

RESPONSIBLE PARTY INFORMATION

Patient's marital status: Single_____ Married_____ Widowed _____ Divorced _____ Separated _____

Person responsible for account (if other than above)_____ Date of Birth: _____/_____/_____
Address:_____ City, State, Zip:_____
No. of years at this address?_____ Previous address (if less than 3 yrs.)_____
Work #:_____ Cell Phone #:_____ Home #:_____
Employer:_____ No. of years Employed:_____
Occupation:_____ SS#:_____

Insurance Company:_____ Orthodontic coverage? Yes_____ No_____
Policy Owner:_____ Group Number:_____
Employer:_____ Address:_____
_____

If Married:
Spouse's Name:_____ SS#:_____
Spouse's Employer:_____ No. years Employed:_____
Occupation:_____ Work Phone #:_____

MEDICAL HISTORY INFORMATION

Physician:_____ Last visit date:_____
Are you currently under the care of a physician? Yes_____No _____
Please describe your current physical health: Good_____ Fair_____ Poor_____
Please list all drugs that you are currently taking:_____
Please list all drugs that you are allergic to:_____

Have you ever had any of the following medical problems?

Yes____ No____ Abnormal bleeding
Yes____ No____ Allergies to any Drugs
Yes____ No____ Hepatitis
Yes____ No____ Hives/Skin Rash
Yes____ No____ HIV+/AIDS
Yes____ No____ Herpes
Yes____ No____ Exposed to HIV, but Neg

Yes____ No____ Hearing Impairment
Yes____ No____ Heart Murmur
Yes____ No____ Tuberculosis (TB)
Yes____ No____ Asthma
Yes____ No____ Convulsions/Epilepsy
Yes____ No____ Latex Allergies
Yes____ No____ Any Tobacco Use

Yes____ No____ Rheumatic/Scarlet Fever
Yes____ No____ Diabetes
Yes____ No____ Congenital/Heart Defect
Yes____ No____ Handicaps/Disabilities
Yes____ No____ Any Operations, If Yes, Please Explain:_____
_____

Please discuss any serious medical problems you have had:_____
_____