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 clinching 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_____