WELCOME

We would like to welcome you to the office of Dr. Kimi S. Caswell.
Our staff is dedicated to providing excellence in orthodontic care.

ADULT INFORMATION

Please tell us a little about yourself

Your name Dr/Mr/Mrs/Ms______________________________________ Preferred Name_______________

Address____ Zip_________________

Home phone_____________________ Cell Phone ______________________Birthdate______________

How long at current address? _________________________ Rent or own? _______________________

Social Security # ___________________________ E-mail address _______________________________

Employer ____Work phone_________________________

Occupation ________________________________ How long at current job? ______________________

Hobbies & interests____

Have you had previous orthodontic treatment?____

If Yes, please describe: ____

What style braces are you interested in?____

What is your primary concern for today's visit?____

____

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

Which office is most convenient for you? Honolulu Kahala Mililani

ADDITIONAL INFORMATION

SELF	SPOUSE
Dental Insurance____________________________	Name______________________________________
Social Security # ___________________________	Address____________________________________
FOR OFFICE USE: Group # __________________	____
Benefits __________________ @ ____________%	Employer___________________________________
Used ______________ How paid _______________	Occupation_________________________________
Phone # ____________________________________	Phone _______________Yrs at current job _______
Spoke with _________________ Date ___________	SS# ______________________ DOB ____________
Notes ______________________________________	Dental Insurance ____________________________

____

Person responsible for account ____

Emergency contact ____ Phone _______________________

HEALTH HISTORY

Are you in good health? Y N, If No, please explain____

Name of Physician____

Have you been hospitalized or had operations?____

If yes, please describe____

Have you had tonsils and adenoids removed? Y N, if Yes, at what age?____________________________

Are you currently taking any medications? Y N, If Yes, please describe____________________________

Do you have any allergies? Y N, If Yes, please explain:____

Are you allergic to LATEX products (i.e. gloves, balloons) Y N, If Yes, please describe:______________

Do you have frequent colds, sore throat, canker sores? Y N, If Yes, please explain:__________________

Do you have frequent headaches or muscle soreness around the head and neck? Y N ______________

If yes, how do you treat the pain?____

Have you been diagnosed or treated for any of the following? (please circle)

Diabetes Epilepsy Blood disorders Pneumonia HIV+ Drug allergy Asthma
Tuberculosis AIDS High Blood Pressure Herpes Rheumatic Fever Fainting
Heart Trouble Convulsions Hepatitis Venereal Disease Endocrine problems
Bone Disorders - Please list other medical conditions, or explain above conditions:____________________

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DENTAL HISTORY

Name of General Dentist____

Date of last visit______________________ What was done?_______________________________________

Are any teeth sore today? Y N, If Yes, please explain____

Have you had any injuries to the face, mouth or teeth? Y N, If Yes, please explain____________________

____

Have you ever sucked your fingers or thumb? Y N, If Yes, until what age?__________________________

Do you breathe primarily through your mouth? Y N ____

Do you clench or grind your teeth? Y N, If Yes, please explain:_____________________________________

Is there clicking or pain on opening or closing the mouth? Y N, If Yes, please explain:________________

Signature:____ Date:____________________

Thank you for providing the above information ☺