



**Delta  
SMILES**  
Specialists in Orthodontics

**Dr. Brent Sexton, DDS, MSD**  
**Dr. John Esterkyn, DDS, MS**  
DeltaSmiles.com

2390 Country Hills Drive,  
Suite 101  
Antioch, CA 94509  
Tel: 925.754.3197  
Fax: 925.754.2090

1145 2nd Street,  
Suite F  
Brentwood, CA 94513  
Tel: 925.513.9320  
Fax: 925.513.2829



Please fill in the information requested with the boxes on both sides of this form. A signature is required.

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Last First Middle

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

Mobile Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Patient's interests \_\_\_\_\_ Name/Age of brothers & sisters \_\_\_\_\_

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 \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

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

How long at this address \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_ Email \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Year Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

Subscriber's Name \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Do you have dual coverage? Yes No

Subscriber's Name \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

I certify that the information on this form is complete and true to the best of my knowledge

I understand that where appropriate, credit bureau Reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

## PATIENT'S MEDICAL HISTORY

Patient's Physician: Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Has patient had their tonsils or adenoids removed? Yes No

Has patient ever had an unusual reaction to any drug? Yes No

Has patient had any of the following? Yes No

1. Arthritis	Yes	No	9. Diabetes	Yes	No	17. Major surgery	Yes	No
2. Anemia	Yes	No	10. Frequent colds	Yes	No	18. Tuberculosis	Yes	No
3. Bleeding problem	Yes	No	11. Allergies/Sinus	Yes	No	19. Heart trouble	Yes	No
4. Epilepsy/Seizures	Yes	No	12. Asthma	Yes	No	20. Thyroid or Hormonal imbalance	Yes	No
5. Nervous disorder	Yes	No	13. Rheumatic Fever	Yes	No	21. Any other serious medical problems	Yes	No
6. Hyperactivity	Yes	No	14. Immune Deficiency	Yes	No			
7. Hepatitis	Yes	No	15. Herpes/Oral-facial	Yes	No			
8. Venereal disease	Yes	No	16. Ulcers	Yes	No			

Does patient have a speech problem and if so, receiving speech therapy? Yes No

Is patient presently under the care of a physician or taking medication? Yes No

Signature ( parent if minor) \_\_\_\_\_ Signature Doctor \_\_\_\_\_

Updated \_\_\_\_\_ Updated \_\_\_\_\_ Updated \_\_\_\_\_

## PATIENT'S DENTAL HISTORY

Patient's General Dentist: Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Does the patient presently suck their thumb or fingers? please circle Yes No

Does the patient breathe mostly through the mouth? Yes No

Has the patient ever received a severe blow resulting in injury to the teeth or jaws?

If yes, please write in details \_\_\_\_\_ Yes No

Does the patient grind their teeth at night? Yes No

In the past, has the patient ever complained of: please circle

Clicking popping stiffness soreness in the jaw or jaw muscles?

Episodes when the jaw would not open or close normally? Yes No

Pain or discomfort in the front of the ear? Yes No

Headaches, neck and or back pain? Yes No

If yes, please write date and details: \_\_\_\_\_

Has patient ever had orthodontic treatment or worn a retainer before? Yes No

Would patient object to wearing orthodontic appl. should they be indicated? Yes No

What is patient's or parent's primary concern? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_