PATIENT INFORMATION

Date_____

Patient's name _____ Male ___ Female ___
First **Middle** **Last** **Nickname**

Address _____ _____
Street City Zip

Home Phone _____ Date of Birth _____ Age _____ Social Security # _____

If patient is a minor, please provide name(s) of parent(s)/guardian(s) _____

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

School_____ Grade_____

Children/Sibling: Name(s) _____Date(s) of Birth _____ Age(s) _____

Please list some hobbies or interests _____

RESPONSIBLE PARTY INFORMATION

Self/Parent/Guardian_____
First Middle Last

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Marital Status: Single___ Married___ Divorced___ Widowed___

Spouse/Parent/Guardian/Other _____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate_____Work Phone_____

Person Financially responsible for this account: Self__ Spouse ___ Parent___ Guardian___ Other _____

DENTAL INSURANCE INFORMATION

(If Dental and/or Orthodontic Coverage, please provide card)

Insured's Name_____ Date of Birth _____Social Security # _____

Employer _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes, complete the following:

Insured's Name_____ Date of Birth _____Social Security # _____

Employer _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

EMERGENCY INFORMATION

Emergency Contact (nearest you)_____ Relationship to Patient _____

Address _____ Phone _____
Street City Zip

MEDICAL HISTORY

Physician_____ Date of Last Visit_____
Address_____ Phone _____

Please circle Yes or No (If Yes, please fill in details):

Yes No Are you in good health? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations or been hospitalized? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Are you taking any prescription and/or over-the-counter medication? _____
Yes No Are you allergic to any medication or substance (including latex or metals)? _____
Yes No Have any tonsils or adenoids been removed? _____

Female Patients only:

Yes No Are you pregnant? _____
Yes No Are you nursing?_____

Children only:

Yes No Has the patient reached puberty?_____
Yes No Has the patient's menstruation begun (girls)?_____
Yes No Has the patient's voice changed (boys)? _____

Please circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Glaucoma	High/Low Blood Pressure	Radiation/Chemotherapy
Anemia	Kidney Disease	HIV+ / Aids	Rheumatic/Scarlet Fever
Arthritis	Leukemia	Liver Disease	Sexually Transmitted Disease
Asthma	Hay Fever/Allergies	Lung/Respiratory Problems	Sinus Problems
Bone Disorders	Heart Attack/Stroke	Migraines/Severe Headaches	Stomach Trouble/Ulcers
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Thyroid Problems
Diabetes	Heart Problems	Pneumonia	Tuberculosis
Dizziness	Hepatitis/Jaundice	Prolonged Bleeding	
Epilepsy/Convulsions/Seizures	Herpes/Cold Sores	Psychiatric Problems	

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

DENTAL HISTORY

General Dentist _____ Phone number_____
Date of most recent dental exam/cleaning/x-rays _____
What are the main concerns that you would like Orthodontics to address? _____

Yes No Have you ever had or been evaluated for Orthodontic treatment? _____
Yes No Are you presently in any dental pain?_____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have you ever been informed of any missing or extra teeth?_____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do your gums bleed when you brush? _____
Yes No Are you aware of your jaw joint clicking or popping (TMJ/TMD)?_____
Yes No Are you aware of clenching/grinding of your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Do you have any speech problems?_____
Yes No Are you a mouth breather?_____
Yes No Has anyone in your family received orthodontic treatment?_____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No If the patient is under age 18, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. In the event of a default on agreed upon payment arrangements, I am responsible for reasonable collection costs.

I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Samuel Lee or Dr. Trang Nguyen to perform a complete orthodontic evaluation.

Signature (Parent/Responsible party if minor): _____ Date:_____
Doctor's signature (verbal review of medical information): _____ Date: _____