*Welcome To Our Office* P.1

**So that we might become better acquainted, please complete this form.**

## ADULT PATIENT INFORMATION

Date _____

Patient's Name _____ Preferred Name _____ Sex _____

Birthdate _____ Age _____ Social Security Number _____

Adress _____ City _____ Zip _____

Home Phone _____

Occupation _____ Employer _____

Employer Address _____ Wk phone _____

Cell Phone _____ Best Phone Number to Call _____

(If you don't have special preference, we'll call your cell phone as first priority)

Whom we may thank for referring you? _____

## FAMILY ACCOUNT INFORMATION

Spouse's Name _____ Employer _____ Wk phone _____

Person responsible for account _____

***IF other than self or spouse:***

Name _____ Occupation _____

Address _____ City _____ phone _____

## INSURANCE INFORMATION

| | **primary** | **secondary** |
|---|---|---|
| Name of insured (Employee) | | |
| Date of Birth (mo/day/year) | | |
| Social Security number | | |
| Insurance Company | | |
| Group Number | | |

### Assignment and release

I, the undersigned certify that I have insurance coverage.I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Lee or Dr. Yeh to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ _____ _____

Responsible Party Signature Relationship Date

adult pt register (leeortho)

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health and orthodontic treatment. I will review this history with you at the initial examination. Information you give me is strictly confidential and will not be released without your permission.

**NAME** _____ 

## MEDICAL HISTORY

PHYSICIANS NAME _____ DATE OF LAST VISIT _____

ADDRESS STREET _____ PHONE _____

CITY _____ STATE _____ ZIP _____

YES NO

☐ ☐ HAS PATIENT UNDERGONE A COMPLETE PHYSICAL DURING THE PAST YEAR?

☐ ☐ IS PATIENT PRESENTLY UNDER A PHYSICIAN'S CARE?

☐ ☐ HAS PATIENT HAD MAJOR SURGERY?

☐ ☐ HAS PATIENT EVER BEEN HOSPITALIZED?

☐ ☐ HAS PATIENT HAD TONSILS AND/OR ADENOIDS REMOVED?

☐ ☐ DOES PATIENT HAVE FAINTING OR DIZZY SPELLS?

☐ ☐ DOES PATIENT HAVE A T00 HIGH OR LOW BLOOD PRESSURE?

☐ ☐ IS PATIENT PREGNANT?

☐ ☐ HAS PATIENT BEEN DIAGNOSED OR TREATED FOR THE FOLLOWINGS?

| | | | |
|---|---|---|---|
| ☐ | HEART PROBLEMS | ☐ | HEPATITIS |
| ☐ | KIDNEY PROBLEMS | ☐ | RHEUMATIC FEVER |
| ☐ | LUNG PROBLEMS | ☐ | NERVOUS PROBLEMS |
| ☐ | LIVER PROBLEMS | ☐ | PSYCHIATRIC CARE |
| ☐ | ALLERGIES | ☐ | MALIGNANCIES |
| ☐ | DIABETES | ☐ | ENDOCRINE PROBLEMS |
| ☐ | EPILEPSY | ☐ | BONE |
| ☐ | ARTHRITIS | ☐ | PROLONGED BLEEDING |
| ☐ | ANEMIA | ☐ | ASTHMA |
| ☐ | TUBERCULOSIS | ☐ | EXPOSURE T0 AIDS |

☐ ☐ IS PATIENT TAKING ANY DRUGS OR MEDICATIONS?

IF YES, LIST THEM _____

_____

_____

PHARMACY NAME & TEL _____

☐ ☐ HAS PATIENT HAD ANY ALLERGIC REACTION T0 ANY MEDICATION?

IF YES, LIST THEM _____

_____

_____

☐ ☐ IS THERE ANY MEDICAL PROBLEMS I SHOULD BE AWARE OF?

(OR ANY ANSWER ABOVE NEED TO BE EXPLAINED)

_____

_____

## DENTAL HISTORY

DENTIST'S NAME _____ DATE OF LAST VISIT _____

ADDRESS STREET _____ PHONE _____

CITY _____ STATE _____ ZIP _____

WHAT'S THE MAJOR CONCERN ABOUT THE PATIENT'S TEETH?

_____

_____

YES NO

☐ ☐ HAS PATIENT HAS PREVIOUS ORTHODONTIC CONSULTATION OR TREATMENT?

☐ ☐ HAS PATIENT BEEN INFORMED OF ANY EXTRA OR MISSING TEETH?

☐ ☐ HAS ANY PERMANENT TEETH BEEN REMOVED BY EXTRACTION?

☐ ☐ HAS ANY FAMILY MEMBER HAD ORTHODONTIC TREATMENT?

WHO? _____

☐ ☐ IS PATIENT NOW SUCKING HIS/HER FINGER?

☐ ☐ DOES PATIENT BREATH PREDOMINANTLY THROUGH THE MOUTH?

☐ ☐ DOES PATIENT HAVE ANY SPEECH PROBLEMS?

☐ ☐ DOES PATIENT GRIND OR CLENCH HIS/HER TEETH?

☐ ☐ DOES PATIENT HAVE PAIN OR CLICKING OF THE JAW JOINTS?

☐ ☐ HAVE ANY TOOTH BEEN INJURED OR CHIPPED DUE TO AN ACCIDENT?

☐ ☐ HAS PATIENT EVER HAD PAINS IN THE FACE OR HEAD?

☐ ☐ HAS PATIENT EVER HAD A JAW OR HEAD INJURY?

☐ ☐ DOES PATIENT'S GUM BLEED ON BRUSHING OR FLOSSING?

☐ ☐ DOES PATIENT GET CHRONIC SORES IN THE MOUTH?

☐ ☐ IS PATIENT CONCERNED ABOUT APPEARANCE OF HIS/HER TEETH?

☐ ☐ DOES PATIENT WANT HIS/HER TEETH STRAIGHTENED?

☐ ☐ ARE THERE ANY OTHER DENTAL/ORTHODONTIC PROBLEMS I SHOULD BE AWARE OF? _____

_____

(OFFICE USE)

UPDATE _____

_____

UPDATE _____

_____

I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

pt Health ortho(leeortho)

SIGNATURE X _____ DATE _____

DOCTOR'S SIGNATURE _____