Welcome To Our Office **CHILD PATIENT INFORMATION** Date _____ p.1

Patient's Name: _____ Preferred Name: _____ Sex: _____

Home Address: _____ City _____ Zip _____

Home Phone: _____ Birthdate: _____ Age _____ School _____ Grade _____

Parent's cell phone _____ Best Phone Number to Call _____

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

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

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient resides with: ☐ Mother ☐ Father ☐ Both ☐ Other

	FATHER	**MOTHER**
Name:		
Address (If different from above):		
Phone (If different from above):		
Social Security Number:		
Employer's Name:		
Business Address:		
Business Phone:		

Person Responsible for Account _____

IF other than parent:

Name _____ Address: _____ Phone: _____

INSURANCE INFORMATION

	PRIMARY	**SECONDARY**
Name of insured (Employee)		
Date of Birth (mo/day/year)		
Insurance Company		
Group Number		
Social Security 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 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 _____ _____

Signature of responsible party Relationship Date

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 _____