PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's name _____ Sex: □ Male □Female
Last First Middle

Address _____
Street City Zip

Home phone_____ Cell/Other Phone _____Email address _____

Birthdate_____ Social Security # _____ Parent or guardian name _____

School_____ Sports/Hobbies _____

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

Is there a specific time of the day or week when you must be seen? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Mailing Address _____
Street City Zip

Home phone_____ Cell/Other phone_____ Email address _____

Social Security # _____Birthdate _____ Relationship to Patient: _____

Spouse's Name _____Birthdate _____ Relationship to Patient: _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insured's Birthdate _____ Insurance Company_____ Group No _____

Insurance Co. Address_____ Phone No_____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insured's Birthdate _____ Insurance Company _____Group No. _____

Insurance Co. Address_____ Phone No_____

X-RAY INFORMATION

It is necessary to take x-rays periodically throughout the orthodontic treatment process. If you have any questions or concerns please let us know.

EMERGENCY INFORMATION

Name of nearest relative not living with you _____Phone No _____

Payment for services is the responsibility of the patient.

In the event you have Orthodontic dental insurance, we will accept direct assignment of benefits if such benefit coverage's can be pre-determined. We will be happy to assist in the preparation of insurance forms.

Signature: _____ Date _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

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

Yes No Is the patient taking any medication? _____
Yes No Has the patient ever taken bisphosphonates (Fosamax, Actonel, etc)? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Female Patients only:
Yes No Has menstruation started (for timing of growth purposes)? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Artificial Joints or Limbs	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any other medical conditions that you feel we should be aware of? _____

Circle any of the allergies or adverse reactions you may have had to the following:

Penicillin	Local Anesthetic	Other Antibiotics	Aspirin
Ibuprofen	Codeine	Latex	Other: _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to hot/cold/ pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Kim to perform a complete orthodontic evaluation which includes digital photographs and x-rays.

Parent or Guardian Signature: _____Date: _____