Kathy Lee, D.D.S.
Specialist in Orthodontics

Welcome to Orthodontics

Shaun Woo, D.D.S.
Specialist in Orthodontics

Tell Us About Yourself

Today's Date:_____ ( ) Male ( ) Female

Name:_____
Last First MI

Nickname: _____ DL# _____

Birthdate: _____ /_____ /_____ Age:_____

Home Address: _____

_____
City State Zip

( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Hm #: _____ Cell #: _____

Wk #: _____ Fax #: _____

Email Address: _____

Employer: _____

Employer's Address: _____

How long there? _____Occupation: _____

Whom may we Thank for referring you?

_____

General Dentist: _____

Phone #: _____

Date of Last Visit: _____

Other family members seen by us: _____

Spouse Information

Name: _____

Employer : _____ Job Title: _____

Hm# _____ Cell# _____

Birthdate:_____/_____/_____

Person Responsible for Account: _____

Hm# _____ Cell# _____

Billing Address : _____

Relation: _____

Employer: _____ DL #: _____

Primary Orthodontic Insurance

Orthodontic Coverage? ( ) Yes ( ) No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

DOB: _____/_____/_____ **ID/SS#:** _____

Employer: _____

Relationship to Patient: _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ( ) Yes ( ) No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

DOB: _____/_____/_____ **ID/SS#:** _____

Employer: _____

Relationship to Patient: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her name: _____

Relation: _____

Hm # :_____

Wk #:_____

Medical History

Do you have a personal physician? ( ) Yes ( ) No

Phone #: _____

Date of Last Visit:_____

Medical History continued

Your current physical health is: ( ) Good ( ) Fair ( ) Poor

Are you currently under the care of a physician? ( ) Yes ( ) No

Please explain : _____

Are you taking prescription/over-the-counter drugs? ( ) Yes ( ) No

Please list each one : _____

For Women: Are you taking birth control pills? ( ) Yes ( ) No

Are you pregnant? ( ) Yes ( ) No # of Weeks : _____

Are you nursing? ( ) Yes ( ) No

Have you ever had any of the following disease or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones/Joints	Y	N	High/Low BP
Y	N	Asthma/Arthritis	Y	N	HIV / AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized
Y	N	Cancer/Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug/Alcohol Abuse	Y	N	Rheumatic
Y	N	Emphysema	Y	N	Severe Headaches
Y	N	Epilepsy/Seizures/Fainting	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sickle Cell Disease
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack/Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers/Colitis
Y	N	Heart Surgery/Pacemaker	Y	N	Venereal Disease

Please list any serious medical condition(s) that you ever had:

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Dental Anesthetic	Y	N	Penicillin
Y	N	Any metals	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to:

_____

Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic treatment?
( ) Yes ( ) No

Have you ever had a serious / difficult problem associated with any previous dental work? ( ) Yes ( ) No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD) ? ( ) Yes ( ) No

Your current dental health is: ( ) Good ( ) Fair ( ) Poor

Do you like your smile? ( ) Yes ( ) No
Gums ever bleed? ( ) Yes ( ) No

Have you ever had an injury to your: Mouth Teeth Chin

Do you generally?

Y	N	Breathe through your mouth
Y	N	Clenching/ Grinding teeth
Y	N	Thumb/ Finger Sucking
Y	N	Nail Biting/Pencil/Pen Biting
Y	N	Tongue Thrusting
Y	N	Speech Problems

Do you have any missing or extra permanent teeth?
( ) Yes ( ) No

Have you ever taken Phen-Fen?
( ) Yes ( ) No
If yes, when? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____Date: _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.
Doctor's Comments:

_____

Doctor's Signature: _____ Date: _____

Your Smile is Our Specialty!

www.lworthodontics.com

Rev. 11/18/11 aa