**John H. Lee, D.M.D., P.C.**
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# ORTHODONTIC PATIENT INFORMATION

Date _____

Patient Name _____ Sex □ M □ F Date of Birth _____ Age _____
Address _____ Phone # _____
School _____ Hobbies/Sports/Music _____
Father _____ Place of Employment _____
Occupation _____ Phone _____
Mother _____ Place of Employment _____
Occupation _____ Phone _____
Names and ages of siblings _____
Dentist's Name and Address _____ Phone _____
Physician's Name and Address _____ Phone _____
Whom may we thank for referring you? _____

## Dental History

What do you wish to gain from orthodontic treatment _____
Other family members had orthodontic treatment? _____
Have you had previous orthodontic consultation? _____
Date of last dental visit: _____ Frequency of dental care: _____
Have there been any injuries to face or teeth? _____
Tonsils removed? Y__ N__ Thumb or Finger sucking? Y__ N__ Lip or Nail Biting? Y__ N__
Any speech problems? Y__ N__ Mouth Breathing? Y__ N__ Clicking/Popping of TMJ? Y__ N__
Any apprehension or unfavorable experience in dental office? Y__ N__
Other information about dental health or previous treatment: _____

## Medical History

Height _____ Weight _____
Currently under the care of a physician? Y__ N__ If so, being treated for what? _____
Hospitalized for any reason? _____

List any medications:
_____
_____

List any drug allergies:
_____
_____

Y__ N__ Rheumatic Fever
Y__ N__ Congenital Heart Disease
Y__ N__ Diabetes
Y__ N__ Pneumonia
Y__ N__ HIV/AIDS
Y__ N__ Asthma
Y__ N__ Hepatitis A,B, or C

Y__ N__ Epilepsy
Y__ N__ Asthma
Y__ N__ Cancer
Y__ N__ Kidney Disease
Y__ N__ Thyroid Disease
Y__ N__ Mental Disorder
Y__ N__ Allergies

Y__ N__ Blood Disorders
Y__ N__ Anemia
Y__ N__ Fainting
Y__ N__ Liver Disease
Y__ N__ Tuberculosis
Y__ N__ Nervous Disorder
Y__ N__ Headaches

If patient is a minor, has patient reached puberty? Y__ N__
Does patient gag, vomit, or faint easily? Y__ N__
*__Does patient require antibiotic pre-medication prior to dental procedures__? Y__ N__
Is there any condition or problem you think we should know about? _____
_____

Turn over and complete other side

## Primary Insurance

Person responsible for Account _____

Insurance Company Name _____ Group # _____

Insured's Name _____ Date of Birth _____

Address (If different)_____ Soc. Sec. # _____

_____ Phone Number _____

Employer Name and Address _____

Business Phone # _____

## Authorization

I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine helpful and healthful orthodontic treatment. If there is any change in my dental or medical status, I will inform the orthodontist.

I authorize the insurance company indicated in this form to pay the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges not paid by my insurance carrier.

Date _____ Signature _____

## Doctor's examination comments:

Angle Class _____ Overbite _____ Other: _____

Max Crowding _____ Overjet _____ _____

Mand Crowding _____ Crossbite _____ _____

Recommendation: Records _____ Recall _____ Not a Candidate _____