Y. Jennifer Choi, DMD, MS
Orthodontics

PATIENT INFORMATION (Adult)

Patient

Date _____

Patient's last name _____ First name _____ Middle Initial _____

Prefer to be called _____

Birth date _____ Age: _____Yrs_____Mos Sex: ☐Male ☐Female

Marital status ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed

Home address _____ City, State, Zip code _____

Home phone ( ) _____-_____ Cell phone ( ) _____-_____

Occupation _____ Employer _____

Work phone _____ Email address _____

Emergency contact: Name _____Phone # _____ relationship _____

General Information

What concerns you about your teeth? _____

Who suggested that you might need orthodontic treatment? _____

Who may we thank for referring you to our office?

Dentist _____ Friend (name) _____ Other _____

Have you had any previous orthodontic treatment/ consultations? _____

Have any other family members been treated in our office? _____

Financial Responsibility

Who is financially responsible for this account? _____ Relationship to patient _____

Address *(if different from patient)* _____ City, State, Zip _____

Home phone *(if different)* _____ Cell phone _____ Email address _____

Social security # _____

Employer _____ Position _____ Work phone _____

Dental Insurance

Primary policy holder's full name _____ Birth Date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't know

Secondary policy holder's full name _____ Birth Date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't know

HEALTH HISTORY

GENERAL PHYSICIAN'S NAME:		GENERAL PHYSICIAN'S LOCATION (CITY):	DATE OF LAST VISIT TO THE PHYSICIAN:

- ***HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS? (All information will be held in strict confidence)***

No.	CONDITION	YES	NO	DON'T KNOW	No.	CONDITION	YES	NO	DON'T KNOW
1.	Allergies or drug reactions				20.	Hormone disorder			
2.	Arthritis (rheumatoid, other)				21.	Kidney disorders			
3.	Asthma				22.	Liver disorders			
4.	ADHD/ADD				23.	Lung disorders			
5.	AIDS or positive HIV test				24.	Nose / throat disorders			
6.	Birth defect/Hereditary problem				25.	Artificial heart valve / Pacemaker			
7.	Bleeding - prolonged				26.	Radiation Tx / Chemotherapy			
8.	Blood disorder / Hemophilia				27.	Replacement joint			
9.	Blood pressure - high or low				28.	Rheumatic fever			
10.	Cancer / tumor				29.	Stomach disorders			
11.	Diabetes				30.	Stroke			
12.	Drug abuse (including alcohol)				31.	Thyroid disorder			
13.	Emotional problems, depression				32.	Tonsils/Adenoids removed			
14.	Epilepsy				33.	Tuberculosis			
15.	Eye problems (glaucoma, other)				34.	Sexually transmitted disease			
16.	Fainting or dizzy spells				35.	Are you taking any medications?			
17.	Hepatitis / hepatitis carrier				36.	Do you smoke?			
18.	Heart murmur				37.	Other (describe below)			
19.	If patient is a minor female, has she had her first menstrual cycle? YES NO (*To help with growth forecasting)*								
No.	FOR ANY "YES" ANSWERS TO THE ABOVE, PLEASE LIST THE NUMBER AND DESCRIBE THE CONDITION:								

DENTAL HISTORY

DENTIST'S NAME:	**DATE OF LAST VISIT TO THE DENTIST:**	FREQUENCY OF DENTAL CHECKUPS:	FREQUENCY OF FLOSSING:

- ***HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS? (All information will be held in strict confidence)***

No.	CONDITION	YES	NO	DON'T KNOW	No.	CONDITION	YES	NO	DON'T KNOW
1.	Allergy to dental injections				14.	Permanent teeth extracted			
2.	Overly anxious about dental treatment				15.	Previous orthodontic treatment			
3.	Bleeding gums				16.	Recurring tooth pain			
4.	Clenching				17.	Sensitivity to cold/heat/sweets			
5.	Dental Surgery				18.	Sinus problems (mouth breathing			
6.	Difficulty chewing or swallowing					or difficult nose breathing)			
7.	Frequent headaches or face pain				19.	Sores in mouth			
8.	Grinding (bruxing) teeth				20.	Speech problems			
9.	**Injury to head, neck, or teeth**				21.	Thumb/finger sucking (Current)			
10.	Jaw locking open or closed				22.	Thumb/finger sucking (Previous)			
11.	Jaw Pain				23.	Unfinished dental treatment			
12.	Noise or clicking in jaw				24.	Unusual growth pattern			
13.	Periodontal disease (gum disease)				25.	Other (describe below)			
No.	FOR ANY "YES" ANSWERS TO THE ABOVE, PLEASE LIST THE NUMBER AND DESCRIBE THE CONDITION:								

Release and Waiver

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Patient Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Patient Signature _____ Date _____