KIM & LEE
ORTHODONTICS

WELCOME TO OUR OFFICE

PATIENT INFORMATION

PLEASE FILL ALL THAT APPLY

Today's Date _____ Patient Date of Birth: _____

Patient Name: _____ Sex: _____ Age: _____

Preferred to be addressed as: _____

If under 18 years of age:

School: _____ Grade: _____

Father/Guardian Name: _____

Mother/Guardian Name: _____

Home Address: _____ City: _____ Zip: _____

Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

Bus. Phone #_____ May we contact you at your work number? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____ Spouse's Occupation: _____

Employer: _____ Bus. Phone # _____

Names of any other Children: _____

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

RESPONSIBLE PARTY INFORMATION

Person responsible for account: _____ Birthdate: _____

Driver's License Number/State: _____ Social Security Number: _____

Relationship to Patient: _____

If other than information reported above:

Home Address: _____ City: _____ Zip: _____

Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____ Bus. Phone #_____

May we contact you at your work number? ☐ No ☐ Yes

INSURANCE INFORMATION

A Dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for all fees incurred. As a courtesy to you, we will gladly submit claims to your insurance company on your behalf providing we have your insurance information. Should your insurance coverage terminate or if the insurance company fails to pay the full benefit, the balance owing would be your responsibility.

Name of Insured:_____SSN:_____Birthdate: _____

Insurance Company:_____

ID No:_____Group No: _____

Second Insurance

Name of Insured:_____ SSN:_____Birthdate: _____

Insurance Company: _____

ID No:_____Group No: _____

MEDICAL HISTORY

Physician's Name:		Date of Last Visit:
Address:		Phone:
Are you in good health?	☐ Yes ☐ No	If No, please explain:
Are you currently under the care of a physician?	☐ Yes ☐ No	For what condition:
Are you currently taking any medicines or drugs?	☐ Yes ☐ No	Name and dosage:
Have you ever taken oral or IV Bisphosphonates?	☐ Yes ☐ No	For what condition:
Are you allergic to anything?	☐ Yes ☐ No	List:
Have you ever been treated for mental or nervous disorders	☐ Yes ☐ No	For what condition:
Have you ever had any serious illness, operation or been hospitalized	☐ Yes ☐ No	For what condition:
Do you have to premedicate/take antibiotics prior to your dental appointments?	☐ Yes ☐ No	For what condition:

MEDICAL HISTORY

--Continued--

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

Please check if you have or had any of the following conditions:

☐ Heart Murmur	☐ Hepatitis	☐ Asthma	☐ Epilepsy
☐ Artificial Heart Valves	☐ Liver Disease	☐ Sinus trouble	☐ Fainting/Dizzy Spells
☐ Rheumatic Fever	☐ Thyroid problems	☐ Tuberculosis	☐ AIDS or HIV
☐ Other Heart Disorder	☐ Diabetes	☐ Arthritis	☐ Herpes
☐ Artificial Joint	☐ Kidney Disease	☐ Thyroid Disorder	☐ High Blood Pressure
☐ Anemia	☐ Growth or Bone Disorder	☐ Other _____	

Height: _____ Weight: _____

Females: Are you pregnant or chance of being pregnant? ☐ Yes ☐ No How many months? _____

Do you take birth control pills? ☐ Yes ☐ No

For Patients Under 18 Only	
Has the patient begun puberty? ☐ Yes ☐ No	If patient is a girl, has menstruation begun? ☐ Yes ☐ No
Has the patient grown in the past year or has their shoe size changed recently? ☐ Yes ☐ No	
Are there any special considerations or precautions you would like for us to be aware of when interacting with your child? If yes, please explain: _____	

DENTAL HISTORY

Dentist's Name:	Telephone:	Date of Last Visit:
Have you ever had any facial or dental injuries?	☐ No ☐ Yes	Explain:
Do you participate in any sports, hobbies, or play any musical instruments?	☐ No ☐ Yes	List:
Have you had any previous orthodontic treatment?	☐ No ☐ Yes	When/where:

DENTAL HISTORY

--Continued—

Have you had any complications associated with previous dental treatment?	☐ No ☐ Yes	Explain:
Have you had any gum problems or gum treatment?	☐ No ☐ Yes	Explain:
How many times a day do you brush and floss your teeth?		
What is your primary concern regarding your teeth?		

Is there a history of (**please mark those which apply**)

☐ Thumb/Finger sucking ☐ Clenching teeth ☐ Jaw joint or muscle soreness

☐ Speech Problems ☐ Grinding teeth ☐ Jaw joint popping or clicking

☐ Mouth breathing ☐ Jaw joint locking ☐ TMJ Therapy

☐ Tooth sensitivity to hold/cold

TO MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT. If there are any changes in the medical history, I will inform the doctor.

Print Name:_____Reviewed by: _____

Patient's/Guardian Signature:_____ Date: _____

Thank you for your time and patience in supplying this important information.

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