

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname _____ Birthdate _____ Social Security # _____

School _____ Sports/Hobbies _____

Parent or guardian name _____

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

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

Updates (date & initial) _____

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 Is the patient allergic to any medication? _____

Yes No History of a major illness? _____

Yes No Has the patient had any operations? _____

Yes No Have seen a physician in the last 12 months? Why? _____

Female Patients only:

Yes No Has menstruation started? If so, when? _____

Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Psychiatric Disorders
Anemia	Dizziness	Herpes	Radiation/Chemotherapy
Asthma or Hayfever	Epilepsy	High Blood Pressure	Rheumatic Fever
Bone Disorders	Heart Murmur	HIV / Aids	Tuberculosis
Congenital Heart Defect	Heart Problems	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

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 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? _____

Yes No Is the patient interested in receiving orthodontic treatment? _____

Yes No Has anyone in the family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Experience jaw clicking or popping? _____

Yes No Aware of clenching or grinding teeth during the day? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____

Yes No Height of parents? Mom _____ Dad _____

Yes No Are you aware that some appointments will be during school hours? _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. In addition, I authorize Dr. Paul Sasaki and Dr. Jennifer Yau to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Dr. Signature: _____ Date: _____