# Patient Information

Patient's Name _____
*Last* *First* *Middle*

Address _____
*Street* *City* *State* *Zip*

Home /Cell Phone _____ Birth Date _____ Social Security #_____

Patient: _____ **Responsible Party:**_____
*Email Address* *Email Address*

**DENTIST NAME** _____ **ADDRESS**_____ **PHONE**_____

**WHO MAY WE THANK FOR RREFERRING YOU TO THE OFFICE** _____

**WHERE HAVE YOU HEARD ABOUT US (Circle all that apply)** FRIEND FAMILY SCHOOL WEBSITE WALK BY LITTLE LEAGUE DENTIST ADVERTISEMENT INVISALIGN.COM COMMUNITY EVENT

## RESPONSIBLE PARTY INFORMATION

Name _____
*Last* *First* *Middle* *Marital Status*

Residence _____
*Street* *City* *State* *Zip*

Mailing Address _____
*Street* *City* *State* *Zip*

How long at this address _____ Home Phone _____ Work Phone _____

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer_____ Occupation_____ No. Of Years Employed _____

## SPOUSE/PARTNER

Spouse's Name _____ Relationship to Patient _____

Spouse's Social Security # _____ Spouse's Birth Date _____

Employer_____ Occupation_____ No. Of Years Employed _____

## INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Employer _____ Occupation _____ No. Years Employed_____
Employer Address _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____ Address_____

## EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship to Patient _____

**PATIENT NAME** _____

# Health History

**Has an orthodontist been consulted previously? Yes No Who?**_____**Were X-rays taken? Yes No**

Is the patient having jaw pain or discomfort at this time? Yes No
Does the patient feel very nervous about having Orthodontic treatment? Yes No
Is the patient taking any medications, drugs or pills? Yes No
If yes, reason: _____
Are you aware of being allergic to or have you ever reacted adversely to any medication or substances (Such as latex or any metals)
If yes, please list: _____

Does the patient require medication prior to dental procedures? Yes No

Indicate which of the following the patient has had or has present. (Circle Yes or No )

| | | | | | |
|---|---|---|---|---|---|
| Adenoids Removed | Yes No | Cosmetic Surgery | Yes No | Liver Problems | Yes No |
| AIDS/HIV | Yes No | Diabetes | Yes No | Kidney Problems | Yes No |
| Anemia | Yes No | Emphysema | Yes No | Mental Health Issue | Yes No |
| Anorexia/Bulimia | Yes No | Endocrine Disorders | Yes No | Mononucleosis | Yes No |
| Arthritis | Yes No | Epilepsy or Seizures | Yes No | Nervousness | Yes No |
| Asthma | Yes No | Fainting or Dizziness | Yes No | Pneumonia | Yes No |
| ADD | Yes No | Hearing Loss | Yes No | Pregnant | Yes No |
| Birth Defect | Yes No | Heart Pacemaker/ | Yes No | Rheumatic Fever | Yes No |
| Hereditary Problems | Yes No | Surgery | Yes No | Rheumatism | Yes No |
| Blood Transfusion | Yes No | Heart Trouble | Yes No | Scarlet Fever | Yes No |
| Bruise Easily | Yes No | Hemophilia | Yes No | Sickle Cell Disease | Yes No |
| Chemotherapy | Yes No | Hepatitis A | Yes No | Sinus Trouble | Yes No |
| Cold Sores | Yes No | Hepatitis B | Yes No | Skin Disorder | Yes No |
| Cortisone Medicine | Yes No | Immune Disorder | Yes No | Stroke | Yes No |

Additional comments or any other information that you can share that will aid us in treating the patient?

_____

Does the patient have any disease, condition or problem not listed? Yes No
If yes, what? _____
Have there been any injuries to the face, mouth, or teeth Yes No
If yes, what? _____
Has the patient ever sucked a thumb or finger? Yes No
If yes, are they still? _____
Does the patient have any speech problems? Yes No
If yes, what? _____
Is the patient a mouth breather? While awake? Yes No While asleep? Yes No

Has the patient ever been informed of any missing or extra permanent teeth? Yes No
If yes, which ones? _____

I have read and understand the proceeding questions. 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. If there are any changes later to this history record or medical/dental status I will inform the practice immediately.

**CONSENT:**
The undersigned hereby authorizes Dr. Cho to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Cho to make thorough diagnosis of the patient's/ my dental needs.

Signature (Parent's signature if minor)_____ Date _____