SAN LEANDRO ORTHODONTICS

Dr. John C. Huang
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Patient Information

Patient Name: (first) __________________________ (middle) ______________________ (last) _________________________

Preferred Name: _________________________ Gender: □ Male □ Female Birth Date: _________________________

Address: ____________________________________ City: ________________________ State: ______ Zip: _____________

Home Phone: _________________________ Cell Phone: _________________________ Work: _______________________

Email Address (where appointment reminders will be sent): ____

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

Friends or family members treated in our office: ____

Responsible Party Information

Name: (first) _______________________________ (middle) ______________________ (last) ___________________________

Address: ____________________________________ City: ________________________ State: ______ Zip: _____________

Mailing Address (if different) _________________________ City: ____________________ State: ______ Zip: ____________

Phone: □ Home: ____________________ □ Work: ___________________ □ Cell: ___________________ (check preferred)

SS#: _____________________________ Birth Date: _____________________ Relationship Patient: ____________________

Employer: ______________________________ How Long?: ______________ Occupation: __________________________

Spouse's Name: (first) ______________________________ (middle) __________________ (last) _____________________

Phone: □ Home: ____________________ □ Work: ___________________ □ Cell: ___________________ (check preferred)

SS#: _____________________________ Birth Date: _____________________ Relationship Patient: ____________________

Employer: ______________________________ How Long?: ______________ Occupation: __________________________

Family Information

(If patient is a child)

The following information is requested so that we can communicate properly with the people involved with your child's treatment

With whom does the patient live (custodial parent)? ____

Who should receive routine information about treatment progress? ____

Who should receive financial information? ____

Are the patient's parents: □ Married □ Separated □ Divorced □ Remarried

Other adults we should know about:

Name: ____ Relationship to Patient: ____________________________

Patient's Siblings (names and ages): ____

Insurance Information

Fill out this section if your dental insurance provides orthodontic benefits.

Insured's Name: ______________________________ SS# _______________________ ID# ___________________________

Insurance Company: __________ ________________ Group # ____________ _______ Employer: ______________________

Dental and Medical History

Is the patient currently under the care of a physician? □ Yes □ No

If yes, for what reason? ______________________________

Physician's Name: ______________________ **Phone #:** ______________________

Dentist's Name: ______________________ **Date of Last Visit:** ______________________

Is the patient seeing any other dental specialist? (e.g., periodontist)? □ Yes □ No

If yes, for what reason? ______________________________

History of major illness? □ **Yes** □ **No**

Any sensitivities or allergies? □ **Yes** □ **No**

Currently taking medications? □ **Yes** □ **No**

If yes, please list (including dosage): ______________________________

Are you currently undergoing or considering starting biosphosphonate treatment (e.g., Fosamax)**?** □ **Yes** □ **No**

If yes, explain: ______________________________

Has the patient been treated for any of the following?

Arthritis	□ Yes	□ No	Blood Disorder	□ Yes	□ No	Nervous Disorder	□ Yes	□ No
Asthma	□ Yes	□ No	Cancer	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Autism/Asberger's	□ Yes	□ No	Diabetes	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Heart Condition	□ Yes	□ No	Epilepsy	□ Yes	□ No	Other	□ Yes	□ No

Is there any special care that would help during the patient's treatment? ______________________________

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Does the patient require antibiotics before dental treatment? □ **Yes** □ **No**

If yes, explain: ______________________________

Have there been injuries to the patient's face, mouth or chin? □ **Yes** □ **No**

If yes, explain: ______________________________

Has the patient ever had pain/tenderness in the jaw joint? (TMJ/TMD)? □ **Yes** □ **No**

Does the patient have any or ever had any of the following habits?

Cheek, tongue or lip chewing	□ Yes	□ No	Clenching teeth	□ Yes	□ No
Finger nail biting	□ Yes	□ No	Tongue thrusting	□ Yes	□ No
Thumb sucking	□ Yes	□ No	Grinding teeth	□ Yes	□ No
Mouth breathing	□ Yes	□ No	Speech problems	□ Yes	□ No

Has the patient been examined by an orthodontist before? □ Yes □ No

If yes, when? ______________________________

Have other members of the family had orthodontic treatment? □ **Yes** □ **No**

If yes, were you happy with the results? □ **Yes** □ **No**

If no, why? ______________________________

In your own words, what is the orthodontic problem? ______________________________

I understand the information given is correct and will be held in the strictest confidence. I also understand that it is my responsibility to inform the office of any changes in the patient's medical or insurance status.

______________________________ ______________________

Signature (legal guardian's signature if patient is a minor) **Today's Date**

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Dr. John C. Huang, DMD DMedSc