Welcome to our office !

ORTHODONTIC ACQUAINTANCE FORM

JETSON S. LEE, D.D.S., M.S.D.

PATIENT'S NAME ____ Date ______________
First Middle Last

Date of Birth ____________ Age ________ Sex _____ Whom may we thank for referring you? ____________________

Responsible Party Information

Name ____ Relationship to patient ______________
First Middle Last

Address

____
Street City State Zip Code

Home Phone # ______________ Social Security # ____________________ Driver's License # ______________

Employer ____________________ Occupation ____________________ Work Phone # ______________

Spouse's Name ____ Relationship to patient ______________
First Middle Last

Social Security # ______________________________ Driver's License # ______________________________

Employer ____________________ Occupation ____________________ Work Phone # ______________

Dental Insurance Information

Insured's Name ____ Relationship to patient ______________
First Middle Last

Insured's Social Security # ______________________________ Insured's Date of Birth ____________________

Insurance Company ______________________________ Group # ______________ Local # ______________

Insurance Co. Address ______________________________________ Phone #

____

Insured's Employer ____________________ Employer's Address

____

Do you have dual coverage? ❑ **Yes** ❑ **No** **If yes:**

Insured's Name ____ Relationship to patient ______________
First Middle Last

Insured's Social Security # ______________________________ Insured's Date of Birth ____________________

Insurance Company ______________________________ Group # ______________ Local # ______________

Insurance Co. Address ______________________________________ Phone #

____

Insured's Employer ____________________ Employer's Address ______________________________

Emergency Information

Name of nearest friend or relative **NOT** living with you ____

Address ____ Phone # ____________________

(Please continue on back)

Medical History

Physician's Name ____________________________ Last Medical Exam ____________ Medical Card # ____________________

Address ____ Phone # ___________________________________

Are you taking any medications now, what? _____________________________ For what purpose? ___________________________

Are you allergic to: ❑ Penicillin ❑ Codeine ❑ Local anesthetic injections ❑ Other

Is your general health good? ❑ Yes ❑ No Reason ____

Any major or unusual illnesses? ❑ Yes ❑ No Reason ____

Are you being treated by a physician now? ❑ Yes ❑ No For What? _______________________________________

Have you ever been diagnosed or treated for any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Heart disease	❑	❑	Hepatitis or liver problems	❑	❑	A.I.D.S.
❑	❑	Congenital heart defect	❑	❑	Jaundice	❑	❑	H.I.V. positive
❑	❑	Rheumatic fever	❑	❑	Stomach problems /ulcers	❑	❑	Venereal disease
❑	❑	Heart murmur	❑	❑	Diabetes	❑	❑	Herpes
❑	❑	Bleeding problems	❑	❑	Epilepsy	❑	❑	Asthma/breathing problems
❑	❑	Anemia	❑	❑	Cancer or leukemia	❑	❑	Tuberculosis or lung disease
❑	❑	Abnormal blood pressure	❑	❑	Frequent headaches	❑	❑	Sinus trouble or hay fever

If yes, please explain

____

Do you have or have had any other diseases or medical problems **NOT** listed on this form? ❑ Yes ❑ No

If so, please explain:

____

Female patients only: Pregnant or possibly pregnant? ❑ Yes ❑ No If yes, how far along? ______________________

Dental History

Reason for this visit? ____ General Dentist ___________________________

Date of last visit _______________ Last X-rays ______________ Are you having any dental pain at this time? _________________

Have you had or do you notice any of the following?

Yes	No		Yes	No	
❑	❑	Teeth sensitive to hot, cold, sweets or pressure	❑	❑	Clenching or grinding of teeth ❑ day ❑ night
❑	❑	Traumatic injury to teeth, mouth , or face	❑	❑	Loosening of your teeth
❑	❑	Pain or tenderness around ear, joint, or side of face	❑	❑	Periodontal treatment
❑	❑	Difficulty in: ❑ Opening ❑ Closing ❑ Chewing	❑	❑	Mouth breathing
❑	❑	Clicking, locking, or popping of jaw joint	❑	❑	Missing teeth
❑	❑	Tonsils or adenoids removed	❑	❑	Additional teeth
❑	❑	Oral habits: ❑ Thumb sucking ❑ Fingernail biting ❑ Cheek biting			
❑	❑	Pain and/or swelling of gums, bleeding of gums when brushing			

If yes, explain

____

What do you feel is wrong with your teeth or bite? ____

Have you had orthodontic treatment? ❑ Yes ❑ No When? ________ Orthodontic consultations? ❑ Yes ❑ No When? _______

Has any member of your family had orthodontic treatment? ❑ Yes ❑ No Who ? ___________________________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I read and understand English.

Signature of patient ____ Date _____________________