YANG ORTHODONTICS

Welcome to our office! In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. You can either print out this form or submit it online. Thank you for your cooperation!

Patient Information

Last Name _____ First name _____ Middle _____

I prefer to be called (Nickname) _____ Gender ○ Male ○ Female

Birth date (MM-DD-YYYY) _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Other Phone _____

Email _____ School _____ Grade _____

Patient siblings (Name and age) _____

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

Responsible Party Information

Responsible Party Last Name _____ First Name _____

Residential Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

How long at this address _____ Home Ph. _____ Work Ph. _____ Cell Ph. _____

Previous Address (if less than 3 yrs) Street _____

City _____ State _____ Zip _____

Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____

Relationship to Patient _____ Employer _____

Occupation _____ Number of years employed with above employer _____

Spouse's Last Name _____ First Name _____

Address (if different) _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell/Other Phone _____

Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____

Relationship to Patient _____ Employer _____

Occupation _____ Number of years employed with above employer _____

Other adults we should know about

Last Name _____ First Name _____

Relationship to Patient _____ Phone _____ Email _____

Emergency Information

Who should we notify in case of emergency _____ Phone _____

Relationship to patient _____

Dental Insurance Information

Primary Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? ◯ Yes ◯ No (If yes, please fill out the Secondary Policy Information below)

Secondary Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Medical History

Physician _____ Phone _____ Date of Last Visit _____

Address _____

Has menstruation (period) begun? ◯ Yes ◯ No ◯ N/A If yes, when? _____

Please fill out the following fields and elaborate as necessary.

◯ Yes ◯ No Is there a current medical problem? _____

◯ Yes ◯ No Is the patient taking any pills, medications, or drugs? _____

◯ Yes ◯ No Is the patient allergic to any medications or anesthetics? _____

◯ Yes ◯ No Is the patient allergic to latex?

◯ Yes ◯ No Is the patient allergic to anything else? _____

◯ Yes ◯ No Has the patient had a serious illness? _____

◯ Yes ◯ No Has the patient had any surgery or been hospitalized? _____

◯ Yes ◯ No Has the patient ever had an injury to the head, face, or mouth? _____

◯ Yes ◯ No Has patient's tonsils and/or adenoids been removed? _____

◯ Yes ◯ No Does the patient snore? _____

◯ Yes ◯ No Is patient sleepy during the day? _____

Please check any of the following conditions the patient has had or currently has

- ☐ Abnormal/Prolonged Bleeding
- ☐ Anemia/Blood Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy / Seizures
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Pneumonia
- ☐ Nervousness / Anxiety
- ☐ Radiation / Chemotherapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Tumor or other growths
- ☐ Stomach Ulcers
- ☐ Tonsillitis
- ☐ Herpes
- ☐ HIV / AIDS
- ☐ Kidney Problems
- ☐ Psychiatric Care
- ☐ Immune System Problems
- ☐ High Blood Pressure
- ☐ Sinus Trouble
- ☐ Fainting
- ☐ Bone Disorders
- ☐ Thyroid / Parathyroid Problems
- ☐ Endocrine Problems
- ☐ Frequent Headaches
- ☐ Hepatitis/Liver Problems
- ☐ Gastrointestinal Disorders

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

_____

Dental History

Who is the patient's dentist? _____

When was the patient last seen by a dentist? _____

What was the reason for the visit? _____

Has any member of the family had orthodontic treatment? _____

What are your main concerns about your child's teeth and what would you like orthodontics to accomplish?_____

_____

Has the patient:

- ◯ Yes ◯ No Had trouble associated with dental treatment? _____
- ◯ Yes ◯ No Had a previous orthodontic treatment or consultation?
  With whom? _____ When _____
- ◯ Yes ◯ No Had any teeth extracted? Why? _____
- ◯ Yes ◯ No Ever injured or broken any teeth? When/what happened? _____
- ◯ Yes ◯ No Ever injured the head or face? When/what happened? _____
- ◯ Yes ◯ No Had any problems with eating, chewing, or swallowing? _____
- ◯ Yes ◯ No Ever sucked ☐ thumb ☐ fingers ☐ bit nails? Until what age? _____
- ◯ Yes ◯ No Dental or facial pain? _____
- ◯ Yes ◯ No Jaw joints make a noise when opening/closing? _____
- ◯ Yes ◯ No Jaw joints cause pain? _____
- ◯ Yes ◯ No Teeth or jaws feel uncomfortable when you awake in the morning? _____
- ◯ Yes ◯ No Clench or grind teeth? _____
- ◯ Yes ◯ No Tension headaches? _____
- ◯ Yes ◯ No Speech problems? _____
- ◯ Yes ◯ No Normally breathe with lips parted? _____
- ◯ Yes ◯ No Swellings or growths in mouth or face? _____
- ◯ Yes ◯ No Had/has periodontal (gum) disease? _____
- ◯ Yes ◯ No Any negative or resistant feelings about orthodontic treatment? _____
- ◯ Yes ◯ No Dissatisfied with appearance of the teeth? _____
- ◯ Yes ◯ No Specifically resistant to: ☐ Braces ☐ Headgear ☐ Retainers
- ◯ Yes ◯ No Is there any other information we should know? _____

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical, dental, or insurance status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained for the purpose of considering payment options.

Responsible Party Signature _____ Date_____

Spouse Signature (required if dual coverage) _____ Date _____