LEE ORTHODONTICS

About You

Today's Date: ____/_____/_____

Email Address: _____

Name: _____
Last First Mi.

I prefer to be called: _____ M F

Birthdate: ___/___/___ Age: ___ SS#: _____

Home Address: _____
Apt #

_____
City State Zip

Single Married Divorced Widowed Separated

Hm #: _____ Cell/Other #:_____

Wk #: _____ Ext: ___ DL #:_____

Employer: _____

Emp Address: _____

How long there?_____Occupation: _____

Whom may we thank for referring you: _____

Other Family Members seen by us: _____

General Dentist: _____Ph#: _____

Last Visit Date: _____

Additional Information

Person Responsible for Account: _____

Hm/Cell #: (_____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

Orthodontic Insurance

Primary

Orthodontic Coverage: Y N Dental Coverage: Y N

Ins Co. Name: _____

Ins Co. Address: _____

Ins Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Subscriber Name: _____ Relation: _____

Subscriber Birthdate: __/___/___ ID/SS#:_____

Subscriber Employer: _____

Secondary

Orthodontic Coverage: Y N Dental Coverage: Y N

Ins Co. Name: _____

Ins Co. Address: _____

Ins Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #): _____

Subscriber Name: _____ Relation: _____

Subscriber Birthdate: __/___/___ ID/SS#:_____

In the event of an emergency, is there someone we should contact?

Name: _____ Relation: _____

Hm/Cell #: (_____)_____

Medical History

Do you have a personal physician? Y N

Phone #: _____ Last Visit: _____

CONTINUED ON BACK...

Medical History Continued.....

Your current physical health is: Good Fair Poor
Are you currently under the care of a physician: Y N
Please Explain: _____

Are you taking any prescription drugs: Y N
Please list each one: _____

For Women: Are you using a prescribed method of birth control? Y N

Are you pregnant: Y N Week #: _____

Are you nursing: Y N

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	Anemia	Y	N	Hepatitis
Y	N	Artificial Bones/Joints	Y	N	Hi/Lo Blood Pressure
Y	N	Asthma/Arthritis	Y	N	HIV+/Aids
Y	N	Blood Transfusion	Y	N	Hospitalization
Y	N	Cancer/Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Drug/Alcohol Abuse	Y	N	Rheumatic/ScarletFever
Y	N	Emphysema	Y	N	Severe/Freq.Headaches
Y	N	Epilepsy/Seizures/Fainting	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sickle Cell Trait/Disease
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Heart Attack/Stroke	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers/Colitis
Y	N	Heart Surgery/Pacemaker.	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following:

Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Penicillin
Y	N	Metals/Plastics	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Other: _____		

Please List any other drugs/materials that you are allergic to:

_____

Dental History

What are the main concerns that you want orthodontics to accomplish?

_____

_____

Ever been evaluated for ortho? Y N
Problem with dental work in the past? Y N
Experienced pain in your jaw joint? Y N
Your current dental health is: Good Fair Poor
Do you like your smile? Y N Gums Bleed? Y N
Injury to: Mouth Teeth Chin
Do you have speech problems? _____
Do you generally breath through your mouth? Y N
If yes: While Awake? While Asleep?
Do you have any missing or extra teeth? Y N
Have you ever taken Fosamax/Bisphosphate? Y N
Have you ever taken Phen-Fen? Y N
Do you smoke tobacco? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____/____/_____
Signature Date

If Lee Orthodontics accepts my dental insurance, I understand that I am responsible for any co-payments/deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to this office.

_____/____/_____
Signature Date

Lee Orthodontics is HIPAA Compliant and is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDC, and ADA.

OFFICE USE ONLY *OFFICE USE ONLY* ***OFFICE USE ONLY*** *OFFICE USE ONLY* ***OFFICE USE ONLY***

I verbally reviewed the medical and dental information above with the patient named herein. _____/____/__
Initials *Date*

Doctors Comments: _____