EVERGREEN ORTHODONTICS

Dr. Gaeun Lee Inc. Certified Specialist in Orthodontics

PATIENT INFORMATION

First Name: Last Name: Gender: M / F			Date of Birth: (MM / DD / YYYY)
Address:	City:		Postal code:
Home #:	Cell #:	Best time to call:	School:
Email	Family Dentist: Dr. _____ in ( )		
How did you hear about our office? □ Dentist _____ □ Newspaper □ Internet □ Friends □ Other_____			

RESPONSIBLE PARTY

Responsible Party I (Relationship with patient:) Name: _____ Contact #: _____ Occupation: _____ Email: _____	**Responsible Party II** (Relationship with patient:) Name: _____ Contact #: _____ Occupation: _____ Email: _____
Dental Insurance (Yes / No) Insurance Company: _____ Employer: _____ Date of Birth: (MM/DD/YYYY)_____ Subscriber ID/Certificate #: _____ Group/Policy #: _____ Coverage:_____	**Dental Insurance (Yes / No)** Insurance Company: _____ Employer: _____ Date of Birth: (MM/DD/YYYY)_____ Subscriber ID/Certificate #: _____ Group/Policy #: _____ Coverage: _____

DENTAL / MEDICAL HISTORY

	Yes	No
Are you in good general health?	____	____
When was your last visit to a family doctor?	_____	
Have you had any serious chronic illnesses or operations?	____	____
How long ago was your last visit to a dentist?	_____	
Do you require pre-medication before dental work? If yes, what condition is this for?	____	____
Are you taking any medications? Please list:_____	____	____
Do you have a history of : (Please circle all that apply)		
(Heart problems, Allergies, Diabetes, Asthma, Fainting, Arthritis, Hepatitis, Rheumatic fever)		
(Snoring, Mouth breathing)		
Do you experience : (Please circle all that apply)		
(Difficulty opening the mouth / 'Popping' or 'clicking' noises from the jaw joints)		
(Pain around the ears or cheek / Pain on opening wide, chewing or yawning)		
(Locked or dislocated jaw)		
Have you ever had injury to the jaw, teeth, mouth, head or neck? (Please circle)		
Does your bite feel uncomfortable or unusual?	____	____
Have you been treated for TMJ (Temporomandibular disorder)?	____	____
Are you under any stress?	____	____
Is there any other health information that we should know about?	____	____
Have you had any previous orthodontic treatment? If yes, please explain:_____	____	____
Have you consulted with another orthodontist?	____	____
Last radiograph taken (Panoramic X-ray)	_____	

If you answered to yes for any of the above, please explain: _____

Date: _____ Name: _____ Signature: _____