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_____			

PARENTS / RESPONSIBLE PARTY (IF NOT PARENT)

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

DENTAL / MEDICAL HISTORY

	Yes	No
Is your child in good general health?	____	____
Has your child had any serious chronic illnesses or operations?	____	____
How long ago was your child's last visit to a dentist?	_____	
Does your child require pre-medication before dental work? If yes, what condition is this for?	____	____
Is your child taking any medications? Please list:_____	____	____
Does your child have a history of : (Please circle all that apply)		
(Heart problems, Allergies, Diabetes, Asthma, Fainting, Arthritis, Hepatitis, Rheumatic fever)		
(Thumb/finger sucking, Nail biting, Snoring, Mouth breathing)		
Does your child 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)		
Has your child ever had injury to the jaw, teeth, mouth, head or neck? (Please circle)		
Does his/her bite feel uncomfortable or unusual?	____	____
Has your child been treated for TMJ (Temporomandibular disorder)?	____	____
Is he/she under any stress?	____	____
Is there any other health information that we should know about?	____	____
Has he/she 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: _____