Lauren Cai, D.D.S., M.S.

A B C

PATIENT INFORMATION

Today's Date: _____ Birthdate: _____

Age: _____

Patient's name:

_____

Last First Middle

Prefers to be called: _____

Address: _____

Street

_____

City State Zip

Home Phone: (____) _____

Parents marital status: (single, married,divorced)

If patient is a minor give parent's or guardian's name:

_____

List other family members seen by us: _____

_____

Email: _____

Whom may we thank for referring you to our office?

_____

RESPONSIBLE PARTY INFORMATION

Name: _____

Last First Middle

Residence: _____

Street

_____

City State Zip

Mailing Address: _____

Street

_____

City State Zip

How long at this address? _____

Home Phone: (____)_____

Work Phone: (____)_____

SSN: _____

Birthdate: _____

Relationship to Patient: _____

Employer: _____

Occupation: _____

Years Employed:_____

SPOUSE INFORMATION

Spouse's Name: _____

Last First Middle

Relationship to Patient: _____

Employer: _____

Occupation: _____

Years Employed: _____

SSN: _____

Birthdate: _____

Work Phone: (____)_____

PRIMARY ORTHODONTIC-DENTAL INSURANCE

Insurance Company:_____

Address:_____

Street

_____

City State Zip

Phone: (____)_____

Group / Policy No: _____

Local No: _____

Insured Name:_____

Last First Middle

Relationship to Patient: _____

Insured Birthdate: _____

Insured Employer: _____

Insured SSN: _____

Orthodontic Coverage: YES NO

SECONDARY ORTHODONTIC-DENTAL INSURANCE

Insurance Company :_____

Address:_____

Street

_____

City State Zip

Phone:(____)_____

Group / Policy No: _____

Local No: _____

Insured Name:_____

Last First Middle

Relationship to Patient: _____

Insured Birthdate: _____

Insured Employer: _____

Insured SSN: _____

Orthodontic Coverage: YES NO

EMERGENCY INFORMATION

Name of nearest relative/friend not living with you:

_____

Last First Middle

Relationship to Patient:_____

Phone: (____) _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____

MEDICAL HISTORY

Name:_____ Age:_____

❑ Male ❑ Female

Have you ever been treated for any of the following? (Please Circle):

Diabetes	Tuberculosis	Endocrine/Thyroid
High Blood Pressure	Anemia	Prolonged Bleeding
Heart Trouble	Epilepsy	Liver Disorder
Rheumatic Fever	Heart Murmur	Asthma
Fainting/Dizziness	Bone Disorder	Kidney Disorder
Hepatitis	Psychological Disorder	Arthritis
Venereal Disease	Cancer/Malignancy	Hay Fever

List any other Medical Conditions:_____

YES NO

___ ___ Are you in good health?
___ ___ Is there any history of major illness?
___ ___ Any drugs or medications currently in use? What?_____
___ ___ Are there any drug sensitivities? List:_____
___ ___ Have you ever had surgery? What type?_____
___ ___ Do you have the tendency for cold sores, sore throats, or ear infections?
___ ___ Are you sensitive to Latex?
___ ___ Do you smoke?

DENTAL HISTORY

Name of current general dentist:_____ Date of last exam:_____

Address: _____

_____

YES NO

___ ___ Have there been any injuries to the face, mouth, or teeth?
___ ___ Have you ever had speech therapy?
___ ___ Are you a mouth breather?
___ ___ Were you or are you currently a thumb sucker?
___ ___ Have you had an adverse reaction to dental anesthesia?
___ ___ Have you been treated for gum disease?
___ ___ Have you had previous orthodontic treatment or consultation? When?_____
___ ___ Do you play any musical instrument? What type?_____
___ ___ Do you clench or grind your teeth?
___ ___ Does your jaw click or pop?
___ ___ Is there difficulty opening wide?
___ ___ Does your jaw ever stick so you can t open/close?
___ ___ Does it hurt to chew?
___ ___ Is there pain in front of your ears?
___ ___ Is there cheek or temple pain?
___ ___ Do you suffer from headaches?
___ ___ Do you have neck or shoulder pain?
___ ___ **What are your concerns about your teeth or jaw?**_____

_____

I have completed this form to the best of my knowledge and it is my responsibility to inform this office of any changes in the medical status:

Signature Guardian / Responsible Party: _____ Date:_____

Reviewed By:_____ Date:_____