



# burlingame orthodontics

Victor S. Lee, DDS, MSD - Specialist in Orthodontics

## WELCOME TO OUR PRACTICE!

Please take a few minutes to complete the following information so we can better care for your orthodontic needs.

### PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  Male  Female  
Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
School/Grade \_\_\_\_\_ E-mail \_\_\_\_\_  
Sister(s)/Age(s) \_\_\_\_\_ Brother(s)/Age(s) \_\_\_\_\_

### PARENTS / GUARDIANS

Name/Relationship _____	Name/Relationship _____
E-mail _____	E-mail _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Occupation _____	Occupation _____
Employer _____	Employer _____
Business Phone _____	Business Phone _____
Mobile Phone _____	Mobile Phone _____

Does the patient live with both parents? \_\_\_\_\_ If no, please elaborate \_\_\_\_\_  
Has any other member of the family been a patient at this office? Names: \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_  
In case of emergency, who should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

### PRIMARY DENTAL INSURANCE

Person responsible for account (Last, First, MI) \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Responsible party employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

### ADDITIONAL DENTAL INSURANCE

Insured Name (Last, First, MI) \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Insured employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_

Today's Date: \_\_\_\_\_

**CHILD (UNDER 18) HEALTH HISTORY**

(Page 1 of 2)

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

### MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Is the patient currently under medical treatment? \_\_\_\_\_ Is the patient taking any medications? \_\_\_\_\_

Has the patient ever had any serious illness and/or operations? \_\_\_\_\_

Has the patient had allergic reactions to any drugs or medications? \_\_\_\_\_ If yes, which ones? \_\_\_\_\_

Does the patient have allergies to nickel or latex? \_\_\_\_\_ (Women only) Is the patient pregnant? \_\_\_\_\_

Please write yes on the line for each medical condition that applies:

_____ ADD	_____ AIDS/HIV	_____ anemia	_____ arthritis/rheumatism
_____ artificial heart valves	_____ asthma/hayfever	_____ bleeding problems	_____ blood disease
_____ bone disorders	_____ cancer	_____ diabetes	_____ emotional problems
_____ epilepsy	_____ fainting/dizzy spells	_____ frequent headaches	_____ frequent colds/flu
_____ heart problems	_____ hepatitis-type _____	_____ herpes	_____ high/low blood press
_____ kidney disease	_____ liver disease	_____ motor difficulties	_____ nervous problems
_____ pneumonia	_____ radiation treatment	_____ sinus problems	_____ stomach ulcer/reflux
_____ stroke	_____ thyroid problems	_____ tonsils/adenoids . . . if removed, age _____	
_____ Tourette's	_____ tuberculosis	_____ vision/hearing problem	_____ other: _____

### DENTAL HISTORY

Dentist's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Date of last complete full mouth x-rays and/or panorex x-ray \_\_\_\_\_

Please write yes on the line for all that apply:

_____ bleeding gums	_____ blisters on lips/mouth	_____ prone to cavities
_____ missing teeth	_____ extra teeth	_____ any teeth extracted
_____ chewing difficulties	_____ speech difficulties . . . if so, please explain _____	
_____ tooth grinding/clenching	_____ severe head and/or facial injuries, please explain _____	
_____ pain or clicking in the jaw joint (TMJ/TMD)	_____ jaw locking on opening or closing	
_____ fingernail, cheek, or lip biting	_____ history of thumb/finger biting/sucking	
_____ difficulty breathing through nose		
_____ Have you ever consulted with an orthodontist? If so, when? _____		
_____ Have you ever had orthodontic treatment? If so, when? _____		
_____ Would you mind wearing braces to straighten your teeth?		

What would you like orthodontic treatment to accomplish? \_\_\_\_\_

What concerns you most about orthodontic treatment:

\_\_\_\_\_ appearance    \_\_\_\_\_ cost    \_\_\_\_\_ length of time    \_\_\_\_\_ pain    \_\_\_\_\_ effectiveness    \_\_\_\_\_ other

**Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.** I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest confidence. I authorize release of any information regarding my treatment to my dental/medical insurance company. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical/dental health.

Signature \_\_\_\_\_ Date \_\_\_\_\_