

Welcome to our office!

We look forward to getting to know you!



Today's Date _____

About You

Mr. Mrs. Ms. Dr.

Name _____ Nickname/Preferred _____

Birthdate _____ Age _____ Male Female

SSN# _____

Home Ph _____ Cell Ph _____ Email _____

Work Ph _____ Ext _____

Employer _____

Residence Information

Home Address _____
Street

City _____ State _____ Zip _____

Who may we thank for referring you to our office? _____ General Dentist _____

Single Married Partnered Divorced Separated Widowed

Account Responsibility Information

Name _____ SSN# _____

Birthdate _____ Relationship to Patient _____

Address (if different from patient's) _____ Home Ph _____
Street

City _____ State _____ Zip _____ Cell Ph _____

Employer _____ Work Ph _____ Ext _____

Orthodontic Insurance

Orthodontic Coverage? Yes No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

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

Policy Owner's Name _____

Please provide a copy of your insurance card/coverage to us. Automatic Yes No

Office Use Only

Lifetime Max _____

Pays at % _____

Deductible _____

Amount used to date _____

Monthly/Quarterly/Other _____

% Initial Placement _____

Emergency Contact Information

Name _____ Phone _____ Relation to patient _____

Payment of Services

Payment is due in full at time of treatment unless prior arrangements have been approved.

If this office accepts my insurance, I understand that I am responsible for payment of service rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits (otherwise payable to me) directly to Dr. Edith Kang. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

Signature _____

Date _____

Continue to other side

About Your Health

How would you describe your health? Good Fair Poor

Physician _____ Phone # _____ Date of Last Visit _____

Are you currently being treated by a physician? Yes No Reason: _____

Please list all drugs/medications you are currently taking (including over the counter): _____

For Women: Are you pregnant? Yes No Week # _____ Are you nursing? Yes No

Are you taking birth control medication? Yes No Medication _____

Do you have any allergies to foods and/or drugs/medications? Yes No

Please list _____

Allergy to (please circle) Latex Yes No Metals/Nickel Yes No Plastics Yes No

Please tell us if you have had any of the following (past and present)? (Please circle)

Y N	Abnormal Bleeding	Y N	ADD/ADHD	Y N	Alcohol/Drug Abuse
Y N	Radiation Therapy	Y N	Colitis	Y N	Difficulty Breathing
Y N	Anemia	Y N	Arthritis	Y N	Asthma
Y N	Bisphosphonate Therapy	Y N	Convulsions/Epilepsy	Y N	Birth Defects/Hereditary Problems
Y N	Cancer/Chemotherapy	Y N	Chest Pain/ Angina	Y N	Emphysema
Y N	Fainting Spells	Y N	Frequent Headaches	Y N	Glaucoma
Y N	Heart Attack/Surgery	Y N	Herpes/Fever Blisters	Y N	High Blood Pressure
Y N	Kidney Problems	Y N	Liver Problems	Y N	Low Blood Pressure
Y N	Mitral Valve Prolapse	Y N	Pacemaker	Y N	Psychiatric Problems
Y N	Shingles	Y N	Sinus Problems	Y N	Sickle Cell Disease/Traits
Y N	Stroke	Y N	Ulcers	Y N	Venereal Disease
Y N	Congenital Heart Defect	Y N	Diabetes	Y N	Handicaps/Disabilities
Y N	Hearing Impairment	Y N	Depression/Anxiety	Y N	Heart Murmur
Y N	Any Hospital Stays	Y N	Hemophilia	Y N	Any Operations
Y N	Hepatitis	Y N	HIV+/AIDS	Y N	Artificial Bones/Joints/Valves
Y N	Lupus	Y N	Tuberculosis	Y N	Rheumatic/Scarlet Fever
Y N	Delayed Growth	Y N	Other(Please explain below)		

Please explain any "Y/Yes" answers _____

Orthodontic/Dental Concerns

Have you been evaluated or had orthodontic treatment before? Y N

Please explain your reason/concern for an orthodontic evaluation: _____

Do you have or have you had any of the following:

Injuries to the face, mouth, teeth or chin? Y N Problem or concern associated with previous dental work? Y N

Pain/discomfort in your jaw joint (TMJ/TMD)? Y N Missing or extra permanent teeth? Y N

Speech problem? Y N Do you still have wisdom teeth? Y N

What is your current dental health? Good Fair Poor

Are you happy with the way your smile looks or the way your teeth look? Y N

What would you change? _____

Do you wish to address/discuss any issues privately (in the absence of people accompanying you today)? Y N

Sign Here

I have read and understand that the information that I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical health status. I will not hold my orthodontist or any member of the office staff responsible for any errors or omissions that I have made in completion of this form. I authorize the office staff to perform the necessary dental services I may need.

Signature

Date

Office Use Only

Doctor's Review Signature: _____ Date: _____

Doctor's Comments: _____