Dr. Richard Lee
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PATIENT INFORMATION

Patient's Full Name _____ Nickname _____

Age _____ Sex _____ DOB _____ SSN _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Siblings (name & age) _____

Sports and/or Hobbies _____

Attends School at _____ Grade_____

GUARDIAN INFORMATION

Name of Mother or Guardian _____

Phone Number (if different than patient) _____ Cell _____

Address (if different than patient) _____

City _____ State _____ Zip _____

Email address _____

Name of Father or Guardian _____

Phone Number (if different than patient) _____ Cell _____

Address (if different than patient) _____

City _____ State _____ Zip _____

Email address _____

INSURANCE INFORMATION

Primary Dental Insurance _____ ID Number _____

Address _____

City _____ State _____ Zip _____ Phone _____

Insured's Name _____ DOB _____ SSN _____

Employer _____ Group Number _____

Secondary Dental Insurance _____ ID Number _____

Address _____

City _____ State _____ Zip _____ Phone _____

Insured's Name _____ DOB _____ SSN _____

Employer _____ Group Number _____

MEDICAL INFORMATION

Who is the patient's physician? _____ Phone _____

Is the patient in overall good health? YES ◯ NO ◯ If no, please explain:

_____

Does the patient have any history of major illness? YES ◯ NO ◯ If no, please explain:

_____

Check any of the following for which the patient has been diagnosed or treated:

☐ ADD/ADHD	☐ AIDS/HIV	☐ Anxiety
☐ Artificial Heart Valve	☐ Asthma	☐ Bleeding abnormally
☐ Bone Disorders	☐ Blood Disease	☐ Cancer
☐ Chemical Dependency	☐ Chemo/radiation	☐ Depression
☐ Diabetes	☐ Eating Disorder	☐ Endocrine
☐ Epilepsy	☐ Fainting/Dizziness	☐ Heart disease
☐ Heart Murmur	☐ Kidney Disease	☐ Liver Disease
☐ Lupus	☐ Mental Illness	☐ Multiple Sclerosis
☐ Muscular Dystrophy	☐ Pneumonia	☐ Nervous Disorder
☐ Hepatitis, Type: ____	☐ Rheumatic Fever	☐ Seizures
☐ Stroke	☐ Transplants	☐ Tuberculosis

Other: _____

Please list any surgeries/hospitalizations that the patient has had in the past year:

_____

Please list any **allergies** to food, medication or metals:

_____

Is the patient allergic to latex? **Y** ◯ **N** ◯ Allergic to nickel? **Y** ◯ **N** ◯

Does the patient have trouble wearing jewelry? **Y** ◯ **N** ◯

Females only: Are you pregnant? Y ◯ N ◯ Are you nursing? Y ◯ N ◯

Please list any **medications** the patient is currently taking: _____

DENTAL INFORMATION

Who is the patient's dentist? _____ Phone _____

When was the patient's last dental appointment? _____

Please describe any injuries to the face, mouth, or teeth that the patient has had:

_____

Please circle YES or NO for all questions below:

Y N Started teething very early or late?
Y N Baby teeth removed that were not loose?
Y N Congenitally missing teeth?
Y N Supernumerary (extra) teeth removed?
Y N Chipped or otherwise injured baby/permanent teeth?
Y N Jaw Fractures, cysts, or mouth infections? Describe above
Y N Sensitivity to hot/cold or teeth throb or ache?
Y N Bleeding gums, bad taste or mouth odor?
Y N Periodontal "gum problems"?
Y N Had periodontal "gum" treatment(s)?
Y N Root canals or "dead" teeth?
Y N Food impaction in between teeth?
Y N Frequent cold or canker sores?
Y N History of speech problems?
Y N Have you ever sucked a thumb or finger/s?
Y N Breath through his/her mouth while awake?
Y N Breath through his/her mouth while asleep?
Y N Grind teeth at night?
Y N Jaw clenching, clicking, or locking?
Y N Any teeth irritating the cheek, lip, tongue, or palate?
Y N Been treated for "TMJ" or "TMD"
Y N Aware or concerned about over or under developed jaw relationships?
Y N Any wisdom tooth problems?
Y N Had any serious trouble with previous dental treatment? If yes, please describe briefly:

_____

I have read and understand the questions above. I will not hold Dr. Richard Lee, Loudoun Orthodontics, or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record/dental status, I understand that it is my responsibility to inform Loudoun Orthodontics as soon as I can while in treatment.

Patient Signature: _____ Date: _____

(or Guardian if patient is under 18 years old)