# Victory Orthodontics

## Soo Yun Stacy Lee, DMD, CAGS

### PATIENT INFORMATION

Patient's Name:_____

Birth Date:_____ Age: _____ Sex: M____ F____

Home Address: _____

City/State:_____ Zip:_____

Home Phone:_____

Business Phone: _____

Pager/Cell Phone: _____

Fax: _____

E-Mail:_____

Patient's Employer or School:_____

Number of Siblings: _____

### RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____

Relationship to Patient: _____

Home Address: _____

City/State _____ Zip:_____

Home Phone: _____

Business Phone: _____

Pager/Cell Phone: _____

Fax: _____

E-Mail: _____

Employer:_____

Social Security #: _____ DOB:_____

### INSURED'S INFORMATION

- Yes ___ No ___ Is patient covered by insurance for orthodontic treatment? Group # _____
  - If Yes, insurance company name _____
- Insured Name _____ Insured Soc. Sec. # _____ Insured DOB: _____
- In case of Emergency contact: _____ Phone: _____
- Family Dentist: _____ Phone: _____ Physician: _____
- Which best describes how you first heard about our office? (Check one)

  ____ dentist ____ dental school ____ friend ____ another orthodontist ____ phone book

  ____ mailer ____ other, please describe _____
  - If you were referred by a friend, whom should we thank? _____

### MEDICAL HISTORY

Has the patient ever had: (Please fill in each blank with "Y" for yes or "N" for no)

| | | | |
|---|---|---|---|
| ___ A.I.D.S. | ___ Auto Immune | ___ Epilepsy | ___ Heart Disease |
| ___ A.I.D.S. Related Complex | ___ Bleeding | ___ Endocrine Problems | ___ Hepatitis |
| ___ Anemia | ___ Blood Disease | ___ Emotional Problems | ___ Herpes |
| ___ Artificial Prosthesis | ___ Bone Disorders | ___ Head or Face Injury | ___ Nervous Disorders |
| ___ Asthma | ___ Diabetes | ___ Hearing Disorder | ___ Rheumatic Fever |

Other (describe): _____

Comments: _____

Yes ___ No ___ Has the patient been under the care of a physician during the past two years, other than for routine examination?

Condition: _____

Drugs or medication currently being used: _____

Birth Defects: _____

Yes ____ No ____ Has the patient reached puberty (menstruation, hair)?

## RESPIRATORY HISTORY

Does the patient:

1. Have allergies to: Seasonal grasses: Yes ____ No ____ Food: Yes ____ No ____
   Drugs: Yes ____ No ____ (If yes, list drugs): Other : _____
   _____ _____
   _____ _____
2. Yes ____ No ____ Snore when sleeping?
3. Yes ____ No ____ Breath through mouth?
4. Yes ____ No ____ Have frequent colds?
5. Yes ____ No ____ Have frequent "stuffy nose?"
6. Yes ____ No ____ Have frequent sore throat or tonsillitis?
7. Yes ____ No ____ Have chewing or swallowing difficulty?
8. Yes ____ No ____ Has the patient received medical treatment from allergist or ear, nose and throat specialist?
   If yes: Dates: _____ By Whom: _____
9. Has the patient had: Nasal Surgery: Yes ___ No ___ Tonsils removed: Yes ___ No ___ Adenoids removed: Yes ___ No ___

## DENTAL HISTORY

Yes ____ No ____ Does the patient have pain or clicking in jaw joint?

Yes ____ No ____ Have any teeth been injured due to accidents or blows to the mouth?

Yes ____ No ____ Has the patient received or been requested to receive speech correction?

Yes ____ No ____ The following habits are of interest. List information as it pertains to this patient:

Yes ____ No ____ Thumb sucking until age _____ Yes ____ No ____ Teeth Grinding

Yes ____ No ____ Finger sucking until age _____ Yes ____ No ____ Tongue thrusting

Yes ____ No ____ Lip-biting or sucking Yes ____ No ____ Other habits

Yes ____ No ____ Has the patient had any unusual dental experiences?

Specify: _____

Date of last dental checkup _____ Were the patient's teeth cleaned? Yes ____ No ____

## ORTHODONTIC HISTORY

- Yes ____ No ____ Has the patient had previous orthodontic consultation? Yes ____ No ____ Previous treatment?
  - Date: _____ Dr.: _____
- Why did patient seek this consultation? _____
- What is the primary problem? _____
- What is expected from orthodontic treatment? _____
- Additional comments you wish to make: _____

_____

_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of individual completing this form: _____

Relationship to patient: _____ Today's Date: _____

Reviewed by Dr.: _____ Date: _____