Rancho Santa Fe Orthodontics
NATALIE LAM | DMD, MMSC

**PATIENT INFORMATION**

Today's Date: _____

Patient's Name: _____ Birthdate: _____ Age: _____

If patient is a minor, provide parent/guardian's name: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email address: _____

Patient's School/Employer: _____Grade/Dept: _____

Hobbies/Sports/Musical Instruments: _____

Patient's Dentist: _____ Referred by:_____

**RESPONSIBLE BILLING PARTY INFORMATION**

Name: _____ Marital Status: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to patient: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Work or Cell Phone: _____

Relationship to patient: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____

**INSURANCE INFORMATION**

Insured's Name: _____ Insured's Member ID #: _____

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____

Insured's Employer: _____ Group #: _____

Do you have secondary insurance coverage? Yes or No If Yes, please fill out the following section:

Insured's Name: _____ Insured's Member ID #: _____

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____

Insured's Employer: _____ Group #: _____

**EMERGENCY CONTACT INFORMATION**

Name of nearest relative not living with you: _____

Address: _____

Phone: _____ Relationship to patient: _____

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**MEDICAL HISTORY OF PATIENT**

Has there been any history of asthma, blood disorders, breathing problems, cancer, diabetes, epilepsy, heart problems, HIV, joint swelling, kidney ailments, liver ailments, sensation or emotional difficulties, TB, or other illness? YES NO

If so, please describe _____

Are you currently under the care of a physician? _____ YES NO

Do you currently take any medications? If yes, list: _____ YES NO

Are there any allergies? (latex, nickel, acrylic, medications) _____ YES NO

Have you had any major surgeries or hospitalizations? _____ YES NO

Do you bleed easily, or is bleeding hard to stop? _____ YES NO

Have you experienced any pain or clicking around the jaw joints? _____ YES NO

Do you suffer from frequent headaches? _____ YES NO

Women: Are you pregnant or nursing? _____ YES NO

**DENTAL HISTORY OF PATIENT**

Approximate date of last dental visit: _____ Date of last x-rays: _____

Have there been many cavities in the past? _____ YES NO

Did any teeth abscess or cause gum boils? _____ YES NO

Do your gums bleed easily when you brush or floss? _____ YES NO

Any serious problems associated with previous dental treatment? _____ YES NO

Have there been any injuries to the teeth? (Chips, falls, blows, etc) _____ YES NO

Have any teeth been removed by extraction? _____ YES NO

Was it suggested that the space be maintained? _____ YES NO

Was an appliance placed? _____ YES NO

Do you breathe mainly through the mouth (are the lips usually parted)? _____ YES NO

Have you ever had a habit of thumb/finger sucking, tongue thrust, or lip biting? _____ YES NO

Have you noticed any speech problems? _____ YES NO

Have you noticed any difficulty chewing food? _____ YES NO

Are you aware of grinding or clenching your teeth? _____ YES NO

Are you aware of any missing or extra teeth? _____ YES NO

Are you dissatisfied with the appearance of your teeth or other facial structures? _____ YES NO

Are you sensitive regarding statements concerning your facial/teeth appearance? _____ YES NO

Has the patient seen an orthodontist before? _____ YES NO

If so, please describe _____

Has anyone in the family had orthodontic treatment? _____ YES NO

If so, please describe _____

What are the concerns that you would like orthodontics to address? _____

_____

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in the patient's medical and dental status. I authorize the orthodontic staff to take dental radiographs, study models, or photos deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

Patient/Parent/Guardian Signature: _____