Yi-Chen Liu
Specialist in Orthodontics DDS, MS

Welcome to our office

PATIENT INFORMATION- Adult

Patient's Name _____ Age _____ Birthdate _____
Last First Middle
Nickname (if preferred) _____ Social Security # _____ Sex: □ M □ F

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Domestic partner

Home Address _____ Home phone (_____) _____

Email address _____ Cell phone (_____) _____

Employer _____ Occupation_____

Work Address _____ Phone (_____) _____

Dentist _____ Phone (_____) _____

Physician _____ Phone (_____)_____

IN CASE OF EMERGENCY, PLEASE CONTACT
Name _____ Relationship _____

Home Phone (_____) _____ Cell Phone (_____) _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Employer _____ Group # _____

Name of Policy Holder _____ Birthdate _____ SSN _____

Insured relationship to patient: □ Self □ Father □ Mother □ Spouse □ Other _____

SECONDARY INSURANCE INFORMATION (IF ANY)

Insurance Company _____ Employer _____ Group # _____

Name of Policy Holder _____ Birthdate _____ SSN _____

Insured relationship to patient: □ Self □ Father □ Mother □ Spouse □ Other _____

DENTAL HISTORY
Reason for today's visit _____

Date of last dental visit _____ Date of last dental xrays _____ Date of last cleaning _____

Have you visited an orthodontist before? □ Yes □ No If YES, for what reason? _____

Have you ever experienced any unfavorable reaction to previous dental treatment? _____

Do you have any of the following habits? □ tongue thrusting □ nail or lip biting □ thumb sucking □ mouth breathing □ smoking

Please indicate Yes or NO to the following:	**YES**	**NO**
Have you ever had treatments for gum disease?.....	□	□
Do your gums bleed? …….	□	□
Have you had any gum boils or swelling? …….	□	□
Are you self-conscious about the appearance of your teeth?.....	□	□
Do your teeth feel loose?.....	□	□
Do you clench or grind your teeth?.....	□	□
Are your teeth sensitive to cold, heat, sweets or pressure?.....	□	□
Has there been any injury to the face, mouth or teeth?.....	□	□

	YES	**NO**
Does your jaw click, pop, hurt or lock?	□	□
Do you have pain in your face/ jaw?.....	□	□
Do you have sores or growths in your mouth? …….	□	□
Do you get blisters on lips or mouth? ……	□	□

How often do you brush? _____
How often do you floss? _____
Additional general dental information _____
_____

MEDICAL HISTORY

Are you currently being treated by a physician? ☐ Yes ☐ No If YES, for what reason? _____

Have you been hospitalized in the past 2 years? ☐ Yes ☐ No If YES, for what reason? _____

Currently taking any medications? ☐Yes ☐ No If YES, please list: _____

Do you need antibiotic pre-medication prior to dental treatments (based on physician instructions)? ☐ Yes ☐ No

Date of last medical exam: _____ Describe your health: ☐Excellent ☐Good ☐Fair ☐Poor

Please mark YES or NO to indicate if you have had any of the following:

	YES	NO		YES	NO
1. Allergies……	☐	☐	13. Rheumatic Fever……..	☐	☐
a) Penicillin or other Antibiotics……	☐	☐	14. Stroke…….....	☐	☐
b) Local anesthetic……	☐	☐	15. Do you have a pacemaker?.....	☐	☐
c) Metal……..	☐	☐	16. High Blood Pressure……	☐	☐
d)Latex……	☐	☐	17. Low Blood Pressure…….	☐	☐
e)Other……	☐	☐	18. Kidney Disease……	☐	☐
2. Arthitis……...	☐	☐	19. Liver Disease, Hepatitis, Jaundice……..	☐	☐
3. Asthma……...	☐	☐	20.Psychiartric Treatment……	☐	☐
4. Blood disease or abnormal bleeding problems…….	☐	☐	21.Radiation Treatment…….	☐	☐
a) Anemia ……...	☐	☐	22. Respiratory Disease…….....	☐	☐
b) Clotting problems…….....	☐	☐	23. Stomach or Duodenal Ulcers……	☐	☐
c) Excessive bleeding requiring treatment……	☐	☐	24.Tumor History……..	☐	☐
d) Other blood disorders……	☐	☐	25. Venereal Disease……	☐	☐
5. Chest Pains, Ankle Swelling, or shortness of breath…..	☐	☐	26. Are You Pregna nt? …….	☐	☐
6. Diabetes……	☐	☐	27. A.I.D.S / HIV+……	☐	☐
7. Glaucoma ……	☐	☐	28.Taking Phen-Fen or Diet Drugs?……	☐	☐
8. Epilepsy……...	☐	☐	29. Taking Bisphosphonates (Fosamax, Boniva, etc)?	☐	☐
9. Fainting……	☐	☐	30. Other medical concerns:_____		
10. Glandular Disease (thyroid, etc.)……	☐	☐	_____		
11. Heart Disease……..	☐	☐	_____		
12. Heart Murmur……	☐	☐			

Please explain particulars regarding any "yes" answers given above: _____

_____

ACKNOWLEDGEMENT AND AUTHORITY

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination and treatment by the doctor. I authorize payment of insurance benefits to the office.

Signed _____ Date_____

Patient, Parent or Guardian

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There is no change, to my personal knowledge, on my medical history.

Initial _____ Initial _____ Initial _____ Initial _____

Date _____ Date _____ Date _____ Date _____