Yi-Chen Liu
Specialist in Orthodontics DDS, MS

# *Welcome to our office*

**PATIENT INFORMATION- Child**

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

Home Address _____ Home phone (_____) _____

Dentist _____ Phone (_____) _____

Physician _____ Phone (_____) _____

**RESPONSIBLE PARTY INFORMATION**

Name _____ Relationship to patient □ Mother □ Father □ Other _____
Last First Middle
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Domestic partner

Home Address _____ Home phone ( _____) _____

Email address _____ Cell phone (_____) _____

Employer _____ Occupation_____

Work Address _____ Phone (_____) _____

**IN CASE OF EMERGENCY, PLEASE CONTACT**
Name _____ Relationship _____

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

**PRIMARY INSURANCE INFORMATION (please let us know if you have dual/ secondary insurance coverage)**

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 _____

Has your child seen an orthodontist before? □ Yes □ No If YES, for what reason? _____

Has your child ever experienced any unfavorable reaction to previous dental treatment? _____

Does your child have any of the following habits? □ tongue thrusting □ nail or lip biting □ thumb sucking □ mouth breathing □ smoking

**Please indicate if any of the following pertains to your child:**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Had treatments for gum disease? | □ | □ | Jaws click, pop, hurt or lock? | □ | □ |
| Have bleeding gums? | □ | □ | Have pain in the face/ jaw? | □ | □ |
| Have gum boils or swelling? | □ | □ | Have sores or growths in the mouth? | □ | □ |
| Self-conscious about the appearance of his/her teeth? | □ | □ | Get blisters on lips or mouth? | □ | □ |
| Have loose teeth? | □ | □ | How often does your child brush? _____ | | |
| Clench or grind teeth? | □ | □ | How often does your child floss? _____ | | |
| Have sensitive teeth to cold, heat, sweets or pressure? | □ | □ | Additional general dental information _____ | | |
| Has there been any injury to the face, mouth or teeth? | □ | □ | _____ | | |

**MEDICAL HISTORY**

Is your child currently being treated by a physician? ☐ Yes ☐ No If YES, for what reason? _____

Has your child been hospitalized in the past 2 years? ☐ Yes ☐ No If YES, for what reason? _____

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

Does your child need antibiotic pre-medication prior to dental treatments (based on physician instructions)? ☐ Yes ☐ No

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

Please mark YES or NO to indicate if your child has 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 child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination and treatment of my child 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 child's medical history.

Initial _____ Initial _____ Initial _____ Initial _____

Date _____ Date _____ Date _____ Date _____