PATRICK C. LEE D.D.S., M.S., INC.
Orthodontics for Children & Adults

ADULT NEW PATIENT FORM

First Name: ____________ Last Name: ____________ Nick Name (if preferred) ____________

Date of Birth: ____ - ____ - ____ Age ____ ❑ Female ❑ Male SS #: ____________

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Domestic Partner DL #: ____________ *State:* ____

Home Address: ____________ Email: ____________

Home Phone #: ____________ Cell #: ____________ Work #: ____________

Employer: ____________ Employer Address: ____________

Occupation: ____________ How Long: ____________

In Case of Emergency, who should we contact? Name: ____________ Phone #: ____________

Who may we thank for referring you? ____________

Other family members seen by us: ____________

INSURANCE INFORMATION

Members Name: (First) ____________ (Last) ____________

Member ID # (SS#): ____________ Date of Birth: ____________

Relation to Patient: ❑ Self ❑ Spouse ❑ Other Other (explain): ____________

Insurance Carrier: ____________ Insurance Phone: ( ) ____________

Insurance Address: ____________

Group, Plan or Policy #: ____________ Employer: ____________

➢➢➢ Please advise us if you have Secondary Orthodontic Insurance ⮜⮜⮜

ALTERNATE BILLING *(please fill out this section if individual listed above is not financially responsible)*

Person(s) Responsible for Account: ____________ Relation: ____________

Home Phone: ( ) ____________ Work Phone: ( ) ____________ Ext: ____

Billing Address: ____________

SS #: ____ - ____ - ____ Driver License #: ____________ *State:* ____ Employer: ____________

Employer Address: ____________

Our office reserves the right to verify the credit status of potential patients and/or financially responsible parties of potential patients prior to extending credit for treatment fees and may, at our discretion, use one or more credit reporting agencies. I understand I am responsible for payment of services rendered. If my insurance is accepted, I am responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize this office to submit insurance billing on my behalf with assignment of benefits made to this office, for services rendered. I understand the information I have provided is correct to the best of my knowledge and that it will be held in the strictest of confidence, and it is my responsibility to update this office of any changes contained herein.

Patient Signature: ____________ **Date:** ____________

MEDICAL HISTORY FORM - ADULT

Patient Name: ______________________ DOB: ____ - ____ - ____ Age: ______

Name of General Dentist: ***Dr.*** ______________________ Address: ______________________

Dentist Phone: (   ) ______________ Date of your last dental cleaning? ______________

What is your attitude towards dentists? *(ex: fearful, shy, looks forward to…)* ______________

Medical History

❑ Yes ❑ No Currently under the care of a physician? Name: ______________ Address: ______________

Please explain: ______________

❑ Yes ❑ No Currently taking any medications? *Please list:* ______________

❑ Yes ❑ No Allergic to aspirin, codeine, anesthetic, amoxicillin/penicillin, erythromycin, sulfa drugs, latex, nickel or any other medications?

Please list: ______________

❑ Yes ❑ No Ever had any serious medical condition, illness, or hospitalization? *Please explain:* ______________

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If female, are you? ❑ Pregnant ❑ Nursing ❑ Taking birth control pills

Have you ever had any of the following medical conditions?

❑ Yes ❑ No Heart defects / problems / surgery
❑ Yes ❑ No Artificial valve / joint
❑ Yes ❑ No Heart murmur
❑ Yes ❑ No Rheumatic / scarlet fever
❑ Yes ❑ No Heart attack / angina / stroke
❑ Yes ❑ No High blood pressure
❑ Yes ❑ No Pacemaker
❑ Yes ❑ No Lung problems, difficult breathing
❑ Yes ❑ No Asthma, emphysema, bronchitis
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Sinus problems, hay fever

❑ Yes ❑ No Blood disorders, excessive bleeding
❑ Yes ❑ No Anemia
❑ Yes ❑ No Blood transfusion / organ transplant
❑ Yes ❑ No Nervous system problems
❑ Yes ❑ No Fainting spells, seizures
❑ Yes ❑ No Recurrent headaches
❑ Yes ❑ No Psychiatric care
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Thyroid disease
❑ Yes ❑ No Immune disorders
❑ Yes ❑ No HIV+ / AIDS

❑ Yes ❑ No Cancer / chemo / radiation tx
❑ Yes ❑ No Bone disorders
❑ Yes ❑ No Arthritis
❑ Yes ❑ No Glaucoma
❑ Yes ❑ No Liver problems, hepatitis
❑ Yes ❑ No Ulcers, Colitis
❑ Yes ❑ No Kidney problems
❑ Yes ❑ No Sexually transmitted disease
❑ Yes ❑ No Fever blisters, herpes
❑ Yes ❑ No Drug / alcohol abuse

Dental History

❑ Yes ❑ No Unhappy with the appearance of your teeth?
❑ Yes ❑ No Are you against wearing braces?
❑ Yes ❑ No Previous orthodontic treatment?
If so, with whom: ______________
❑ Yes ❑ No Consulted an orthodontist before?
If so, with whom: ______________
❑ Yes ❑ No Has dentist recommended treatment?
❑ Yes ❑ No Have any family members had treatment?
❑ Siblings ❑ Children ❑ Parents
❑ Yes ❑ No Mouth breathing while awake or asleep
❑ Yes ❑ No Speech problems
❑ Yes ❑ No Excessive cheek biting
❑ Yes ❑ No Excessive trapping of food between teeth
❑ Yes ❑ No Chipping of front teeth

❑ Yes ❑ No Grinding or wear on teeth
❑ Yes ❑ No Injuries to the face, mouth, or teeth
❑ Yes ❑ No Difficulty brushing or flossing
❑ Yes ❑ No Difficulty biting or chewing
❑ Yes ❑ No Difficulty in opening or closing the jaws
❑ Yes ❑ No Clicking or popping of the jaw
❑ Yes ❑ No Pain (jaw joint, ear, side of face)
❑ Yes ❑ No Missing or extra permanent teeth
❑ Yes ❑ No Tonsil and adenoids removed
❑ Yes ❑ No Biting / chewing habit (circle): toothpick, shirt, gum, ice, pen, pencil, fingernail, thumb, finger, lip, straw
❑ Yes ❑ No Smoke tobacco
❑ Yes ❑ No Play a musical instrument
❑ Yes ❑ No Play active sports

I understand that the information that I have provided is correct to the best of my knowledge. I will inform this office of any changes to my medical and dental health. I consent to the performing of oral examinations and other necessary dental services by the dental staff. This office is HIPAA, OSHA, CDC and ADA Compliant and are committed to upholding and exceeding the standards set by these entities.

Patient Signature: **Patient Name:** **Date:**

For Office Use Only: ______________

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Medical Hx Reviewed by: ______________ Date: ______________