

PAUL Y. LEE, D.D.S.

Patient Registration
History-Adult

Practice Limited to Orthodontics

* 10251 Torre Avenue Ste. #118 Cupertino, CA 95014 (408) 996-1204

* 995 Montague Expressway Ste. #117 Milpitas, CA 95035 (408) 946-0766

MR. ___ MRS. ___ MALE ___ FEMALE ___

MS. ___ DR. ___

NAME _____ HOME PHONE _____

FIRST MIDDLE LAST

HOME ADDRESS _____

(STREET) (CITY) (STATE) (ZIP)

EMPLOYER _____ BUSINESS PHONE _____

OCCUPATION _____ E-MAIL _____ CELL _____

ADDRESS _____

SOC. SEC. # : _____ DATE OF BIRTH: _____ AGE: _____

MARRIED Y/N SPOUSE NAME _____ REFERRED BY: _____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____ DATE OF LAST VISIT _____

ADDRESS _____ DATE OF LAST X-RAY _____

DATE OF LAST CLEANING _____ ANY PENDING WORK? _____

WHAT IS YOUR MAJOR CONCERN ABOUT YOUR TEETH? _____

	YES	NO		YES	NO
Have you ever had previous orthodontic consultation or treatment?	___	___	Do you grind or clench your teeth?	___	___
Have you ever been informed of any extra or missing teeth?	___	___	Do you have pain or clicking of the	___	___
Have any permanent teeth been removed by extraction?	___	___	jaw joint? L/R	___	___
Have any teeth been injured or chipped due to an accident?	___	___	Do you ever have pain the face	___	___
Has any family member had orthodontic treatment?	___	___	or ear? L/R	___	___
Who? _____			Have you ever had severe jaw or	___	___
Do you have finger or nail biting or other habit?	___	___	head injury	___	___
Do your gums bleed on brushing or flossing?	___	___	Do you breath predominantly through	___	___
Do you have any speech problem?	___	___	the mouth?	___	___
Are there any other dental/orthodontic problems we should be aware of?	___	___	IF YES, PLEASE EXPLAIN _____		

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT _____

ADDRESS _____ MED ID# _____

	YES	NO		YES	NO	YES	NO
Have you under gone a physical exam in the past year?	___	___	Have you ever been diagnosed or treated for the following?				
Are you presently under a physician's care?	___	___		YES	NO	YES	NO
Have you ever had a major surgery?	___	___	Heart Problems	___	___	Hepatitis	___
Have you ever been hospitalized?	___	___	Kidney Problems	___	___	Rheumatic Fever	___
Are you taking any pills, medications or drugs?	___	___	Lung Problems	___	___	Emotional Problems	___
Are you allergic to novocaine or penicillin?	___	___	Liver Problems	___	___	Malignancies	___
Have you ever had an unusual reaction to any medications?	___	___	Allergies	___	___	Endocrine Problems	___
Have you had tonsils and/or adenoids removed?	___	___	Diabetes	___	___	Bone	___
Do you have fainting or dizzy spells?	___	___	Epilepsy	___	___	Prolonged Bleeding	___
Do you have a too high or low blood pressure?	___	___	Anemia	___	___	Tuberculosis	___
Are there any other medical problems we should be aware of?	___	___	Arthritis	___	___	Asthma	___
			IF YES, PLEASE EXPLAIN _____				

(Please see next page)

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of insured _____
Relationship to patient _____
Insurer's B-day _____ Soc. Sec.# _____
Employer _____
Insurance Company _____
Group # _____ Employee Cert.# _____
Insurance Phone # _____

ADDITIONAL INSURANCE

Name of Insured _____
Relationship to patient _____
Insurer's B-day _____ Soc. Sec. # _____
Employer _____
Insurance Company _____
Group # _____ Employee Cert. # _____
Insurance Phone # _____

Patient's Signature: _____

Date: _____
