Daniel L. Le, DDS, PA
Board Certified Orthodontist

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Board Certified Pediatric Dentist

Cypress
Orthodontic and Pediatric Dentistry

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MEDICAL DENTAL HISTORY FORM ADULT PATIENT INFORMATION

Date___________________

Name____Age________

Date of birth______________________ Sex____________ SSN______________________

Home Address ____

City________________________State____________________Zip_______________________

Home phone_________________ __________Cell Phone_______________________________

Email Address____

Employer______________________________________Occupation________________________

Year's employed______________________________Work phone________________________

Whom may we thank for referring you to our office?___________________________________

If not refer how did you hear about us?____

DENTAL INSURANCE INFORMATION

Do you have dental insurance? [ ] Yes [ ] No If Yes:

Insurance Co. Name_________________________ Insurance Co. Phone____________________

Insurance Co. Address____

Group #_________________________________ID#___________________________________

Insured's Name ________________________Relationship to Patient_______________________

Insured's Birth Date_____________________Insured's Employer__________________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insurance Co. Name_________________________ Insurance Co. Phone____________________
Insurance Co. Address____

Group #________________________________ID#__________________________________

Insured's Name _______________________Relationship to Patient______________________

Insured's Birth Date____________________Insured's Employer__________________________

MEDICAL HISTORY

Place check in the YES or NO column	Yes	No
1. Are you allergic to any medications?______________________	____	____
2. Have you had any serious illness, operation, or hospitalization in the past?	____	____
3. Has there been a change in your health in the last 2 years?	____	____
4. Are you a "bleeder" or have you had excessive bleeding following dental treatment?	____	____
5. Are you presently under the care of a physician?	____	____
6. Do you smoke or use tobacco products? How much? _______ How long? ______	____	____
7. Do you drink alcoholic beverages?	____	____

8. HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
High Blood Pressure	___	___	Angina	___	___	Aids of related Complex	___	___
Heart Murmurs	___	___	Heart Attack	___	___	Blood disorders	___	___
Prolapsed Mitral Valve	___	___	Pacemaker	___	___	Joint Implants	___	___
Rheumatic Fever	___	___	Emphysema	___	___	Nervous Disorder	___	___
Heart Problems	___	___	Asthma	___	___	Epilepsy / Seizures	___	___
Heart Bypass Surgery	___	___	Dialysis	___	___	Steroids Last 2 Years	___	___
Kidney Disease	___	___	Tuberculosis	___	___	Radiation / Chemo	___	___
Chemical Dependency Treatment	___	___	Stroke	___	___	H.I.V. Positive	___	___
Hepatitis / Liver Disease	___	___	Diabetes	___	___			
Oral Surgery Complications	___	___	Arthritis	___	___	**Women Only:**		
Thyroid Disorders	___	___	Headaches	___	___	Pregnant	___	___
Bleeding Problems	___	___	Cancer	___	___	Breast Feeding	___	___

9. List **ANY** drugs or medicines that you are currently taking…include prescription / non-prescription drugs, Aspirin, Birth control pills, and vitamins.

DRUG	DOSAGE / HOW OFTEN?	HOW LONG?
__________________________	______________________________	________________
__________________________	______________________________	________________
__________________________	______________________________	________________
__________________________	______________________________	________________

Physician name_____________________________ Phone #____________________________________

Last Seen/Reason____

DENTAL HISTORY

General Dentist Name____

Date of last visit___________________________________Last cleaning date:_____________________

Have you had periodontal treatment before? If yes, when and where?_____________________________

What concerns you most about your gum mouth or teeth?

____

Yes No Are you presently in any dental pain?____

Yes No Have there been any injuries to face, mouth, or teeth?______________________________

Yes No Is any part of your mouth sensitive to temperature? Where?________________________

Yes No Is any part of your mouth sensitive to pressure? Where?___________________________

Yes No Do you have any type of thumb or tongue habit? __________________________________

Yes No Have you ever seen and or treated by an orthodontist? If yes, who and when?__________

Yes No Do your teeth or jaws ever feel uncomfortable first thing in the morning? _____________

Yes No Do you experience jaw clicking or popping?_____________________________________

Yes No Aware of clenching or grinding teeth during the day?______________________________

Yes No Have you ever experienced chronic ringing in the ears?____________________________

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history during the course of care. In addition, I authorize Dr. Le and the dental staffs to take photographs, x-rays and perform the necessary dental services I may need to perform a complete orthodontic evaluation.

Patient Signature____Date________________