HAESIN SABINA JUNG, D.D.S., P.C
FAMILY ORTHODONTICS
EMAIL: INFO@ORTHOBITE.COM

Confidential Biographical Information

Name:_____ Birthdate:_____ SS#(over18yrs/self)_____
Main Phone #_____ Text: ☐ **Y** ☐ **N** Email Address:_____
Address:_____City:_____State:_____Zip:_____
School:_____Grade:_____
Whom May We Thank for Referring You?_____

Confidential Financial Party Information

☐ **Check if the patient is also the person who will be financially responsible for treatment.**

Father's Name:_____ DOB:_____ SS#:_____
Address: **(If different from above)**_____
Main Phone# _____Text ☐**Y** ☐**N** Email Address:_____
Employer:_____ Occupation/Position:_____
Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐ Widowed ☐ Remarried

Mother'sName:_____DOB:_____SS#:_____
Address: **(If different from above)**_____
Main Phone# _____Text ☐ **Y** ☐ **N** Email Address:_____
Employer:_____Occupation/Position:_____
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Dental Insurance Information

Policy Holder's Name:_____ Relationship to Patient:_____
Insurance Company:_____ INS Telephone#_____
Member ID#_____ Insurance Group/Local#_____
Ins. Address:_____ City:_____ State:_____ Zip:_____

Do you have dual dental Coverage? ☐ **Y** ☐ **N** **If so, please provide Secondary Insurance Company below:**

Policy Holder's Name:_____ Relationship to Patient:_____
Insurance Company:_____ INS Telephone#_____
Member ID#_____ Insurance Group/Local#_____
Ins. Address:_____ City:_____ State:_____ Zip:_____

Dental History

Dentist Name:_____ Last Dental Visit:_____
Has the patient had an orthodontic treatment? ☐ **Y** ☐ **N**
If Yes, what is the name of orthodontist?_____
What is the main orthodontic concern? _____

Please select YES if the patient has had any of the conditions listed below either now or in the past.

1. Speech problems/therapy? ☐Y ☐N
2. Injury to face, jaw, teeth or mouth? ☐Y ☐N
3. Frequent headaches? ☐Y ☐N
4. Chipped or injured permanent teeth? Y ☐N
5. Teeth sensitive to hot or cold? ☐Y ☐N
6. Previous root canal therapy? ☐Y ☐N
7. Previous periodontal (gum) therapy? ☐Y ☐N
8. Do gums bleed? ☐Y ☐N
9. Brush teeth daily? ☐Y ☐N
10. Floss teeth daily? ☐Y ☐N
11. Frequent canker sores or cold sores? ☐Y ☐N
12. Mouth breathing? ☐Y ☐N
13. Snores during sleep? ☐Y ☐N
14. Missing or extra permanent teeth? ☐Y ☐N

15. Thumb sucking/pacifier usage as child? ☐Y ☐N
16. Current thumb/digit sucking habits? ☐Y ☐N
17. Is all dental work completed? ☐Y ☐N

If any of the above dental questions were answered 'Yes', please explain:

_____

18. Have you had a TMJ screening? ☐Y ☐N
19. Do you have a history of jaw joint problems? ☐Y ☐N
20. Have you been treated for TMJ? ☐Y ☐N
21. Do you have clicking/popping in your jaw? ☐Y ☐N
22. Clench or Grind teeth? ☐Y ☐N
23. Pain, tenderness or noise in either jaw? ☐Y ☐N
24. Has your jaw ever locked? ☐Y ☐N
25. Difficulty in chewing or opening mouth? ☐Y ☐N
26. Do you experience soreness in the muscles of your face or around your ears? ☐Y ☐N

If any of the above TMJ questions were answered 'Yes', please explain:

_____

Medical History

Physician's Name:_____

1. Has there been any change in he patient's general health within the last year? ☐Y ☐N
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐Y ☐N
3. Are you taking any medication(s) including non-prescription medicine? ☐Y ☐N
   ***If yes, what medication(s) are you taking?**
   _____
4. Do you allergies or reaction to the following?
   *Latex ☐Y ☐N *Penicillin or other antibiotic ☐Y ☐N *Metal Allergy ☐Y ☐N
   *Sulfa Drugs ☐Y ☐N *Aspirin, Ibuprofen, Tylenol ☐Y ☐N
5. Do you have or had any of the following medical condition? **ONLY CHECK if YES**

☐Arthritis	☐Asthma	☐Cancer
☐Cardiac Pace Maker	☐Chest Pains	☐Diabetes
☐Chronic Fatigue	☐Epilepsy/Convulsions	☐Fainting/ Seizures
☐Hay Fever/Allergies	☐Heart Disease	☐Heart Murmur
☐Hepatitis	☐High Blood Pressure	☐Kidney Disease
☐Leukemia	☐Liver Disease	☐Respiratory Problems
☐Stomach troubles/ Ulcer	☐Thyroid Problem	☐Other:_____

Patients Under 18

1. Has patient begun puberty: ☐Y ☐N
   a. If patient is a girl, has menstruation begun: ☐Y ☐N
   b. If patient is a boy, has their voice changed or have facial hair: ☐Y ☐N
2. Has either biological parent ever had orthodontic treatment? ☐Y ☐N ☐Don't Know

---

☐ I certify that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____

Signature of Responsible Adult Date