HAESIN SABINA JUNG, D.D.S., P.C.
FAMILY ORTHODONTICS

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CONFIDENTIAL INFORMATION: PATIENT'S CLINICAL HISTORY *(PLEASE COMPLETE IN INK)*

NAME _____ BIRTHDATE _____ SS# (OVER 18YRS/SELF) _____

HOME PHONE # _____ CELL PHONE# _____ **(TEXT: Y/N)** EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SCHOOL _____ GRADE _____

CONTACT # TO REACH DURING BUSINESS HOURS: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

FATHER'S INFORMATION

FIRST _____ LAST _____ DOB _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL PHONE# _____ **(TEXT: Y/N)** EMAIL _____

EMPLOYER _____ OCCUPATION/POSITION _____

BUSINESS ADDRESS _____ WORK PHONE: _____

MARITAL STATUS (CIRCLE): SINGLE MARRIED SEPARATED DIVORCED WIDOWED REMARRIED

MOTHER'S INFORMATION

FIRST _____ LAST _____ DOB _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL PHONE# _____ **(TEXT: Y/N)** EMAIL _____

EMPLOYER _____ OCCUPATION/POSITION _____

BUSINESS ADDRESS _____ WORK PHONE: _____

MARITAL STATUS (CIRCLE): SINGLE MARRIED SEPARATED DIVORCED WIDOWED REMARRIED

PRIMARY DENTAL INSURANCE INFORMATION

INSURED NAME _____ RELATIONSHIP TO PATIENT _____

DATE EMPLOYED _____ DOB _____ SS# _____

INSURANCE COMPANY NAME: _____ INS TEL: _____

MEMBER ID#: _____ INSURANCE GROUP/LOCAL# _____

INS. ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY DENTAL INSURANCE INFORMATION (IF YES)

INSURED NAME _____ RELATIONSHIP TO PATIENT _____

DATE EMPLOYED _____ DOB _____ SS# _____

INSURANCE COMPANY NAME: _____ INS TEL: _____

MEMBER ID#: _____ INSURANCE GROUP/LOCAL# _____

INS. ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT'S NAME _____ TODAY'S DATE _____

FAMILY DENTIST _____ FAMILY'S PHYSICIAN _____

PATIENT MEDICAL HISTORY

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW:	____	____
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS:	____	____
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	____	____
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	____	____
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	____	____
6. ARE YOU WEARING CONTACT LENSES?	____	____

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO MEDICATIONS?
(IE. ASPIRIN, PENICILLIN, SULFA DRUGS, ETC. IF YES, WHAT? _____

8. ***WOMEN ONLY:***	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	____	____
B) ARE YOU NURSING?	____	____
C) ARE YOU TAKING BIRTH CONTROL PILLS?	____	____

PLEASE COMMENT ANY OTHER SIGNIFICANT INFORMATION ABOUT THE PATIENT'S MEDICAL HISTORY: _____

9. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? CHECK IF YES.

AIDS OR HIV INFECTION	____	GLAUCOMA	____	LOW BLOOD PRESSURE	____
ANGINA	____	HAY FEVER/ALLERGIES	____	RADIATION THERAPY	____
ARTHITIS	____	HEART ATTACK	____	RECENT WEIGHT LOSS	____
ASTHMA	____	HEART DISEASE	____	RESPIRATORY PROBLEMS	____
CANCER	____	HEART MURMUR	____	RHEUMATIC FEVER	____
CARDIAC PACE MAKER	____	HEART TROUBLE	____	STD	____
CHEST PAINS	____	HEPATITIS/JAUNDIS	____	STOMACH TROUBLES/ULCERS	____
DIABETES	____	HIGH BLOOD PRESSURE	____	STROKE	____
EASILY WINDED	____	JOINT REPLACEMENT OR IMPLANT	____	SWOLLEN ANKLES	____
EMPHYSEMA	____	KIDNEY DISEASES	____	THYROID PROBLEM	____
EPILEPSY/CONVULSIONS	____	LEUKEMIA	____	TUBERCULOSIS	____
FAINTING/SEIZURES	____	LIVER DISEASE	____	OTHER _____	

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	____	____
2. Are your teeth sensitive to hot or cold liquids/foods?	____	____
3. Are your teeth sensitive to sweet or sour liquids/foods?	____	____
4. Do you feel pain to any of your teeth?	____	____
5. Do you have any sores or lumps in or near your mouth?	____	____
6. Have you had any head, neck, or jaw injuries?	____	____
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking	____	____
b) Pain (joint, ear, side of face)	____	____
c) Difficulty in opening or closing	____	____
d) Difficulty in chewing	____	____
8. Do you have frequent headaches?	____	____

	YES	NO
9. Do you clench or grind your teeth?	____	____
10. Do you bit your lips or cheeks?	____	____
11. Have any wisdom teeth been removed? How many	____	____
12. Have you had any orthodontic work?	____	____
If yes, when _____		
If yes, doctor's name _____		
13. Have you ever had treatment for a periodontal disease (gum disease)?	____	____
14. Have your jaws ever "locked" **CLOSED**?		
If yes, describe _____		
15. Have your jaws "locked" wide **OPEN**?		
If yes, describe _____		

GROWTH AND DEVELOPMENT

YES	NO	
____	____	Girls – Has monthly cycle started yet? If so, when _____
____	____	Boys – Has voice changed yet? If so, when _____
____	____	Are there any learning disabilities? If yes, explain _____
____	____	Has any other family member had orthodontics treatment? _____
____	____	Has any other family member been a patient in this office? Name: _____

Please describe why you sought this consultation _____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. 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 a clinical examination.

_____ _____

(Signature of Responsible Adult) Date

Doctor's Notes _____

_____ Date: _____ Signature: _____