LINDA HUYNH DDS, MS
ORTHODONTICS
FOR CHILDREN AND ADULTS

## PATIENT INFORMATION

Date__________________ Male ___ Female ___

**Patient's name** ______________________________________________
First Middle Last Nickname

Address ______________________________________________
Street City Zip

Home Phone ________________ Date of Birth ____________ Age _____ Social Security # ________________

If patient is a minor, please provide parent's/guardian's name ________________________________

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

General Dentist ________________________ Phone ____________ Date of last visit ______________

School__________________________ Grade__________

Children/Sibling: Name(s) ________________________Date(s) of Birth ______________ Age(s) ________

## RESPONSIBLE PARTY INFORMATION

**Self/Parent/Guardian** ______________________________________________
First Middle Last

Residence ______________________________________________
Street City Zip

Mailing Address ______________________________________________
Street City Zip

How long at this address?______ Home phone__________________ Work phone ________________

Cell/other phone__________________ Email address ________________________________

Previous Address (If less than 3 years) ________________________________

Social Security #____________________ Birthdate____________ Relationship to Patient ______________

Employer__________________________ Occupation______________ No. years employed ____________

Marital Status: Single___ Married___ Divorced___ Widowed___

**Spouse/Parent/Guardian/Other** ________________________________ Relationship to Patient____________

Employer__________________________ Occupation______________ No. years employed ____________

Social Security #________________________ Birthdate ________________Work Phone ______________

**Person Financially responsible for this account**: Self__ Spouse ___ Parent___ Guardian___ Other ____________

## DENTAL INSURANCE INFORMATION

(If Dental and/or Orthodontic Coverage, please provide card)

Insured's Name________________________ Date of Birth ___________Social Security # ______________

Employer ______________________________________________

Insurance Company____________________ Group No.______________ Local No. ________________

Insurance Co. Address____________________________________ Phone No.________________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name________________________ Date of Birth ___________Social Security # ______________

Employer ______________________________________________

Insurance Company____________________ Group No.______________ Local No. ________________

Insurance Co. Address____________________________________ Phone No.________________

## EMERGENCY INFORMATION

Emergency Contact (nearest you)______________________________ Relationship to Patient ______________

Address ______________________________________ Phone ________________
Street City Zip

## MEDICAL HISTORY

Physician ______________________________ Date of Last Visit ______________
Address ______________________________ Phone ______________

***Please circle Yes or No (If Yes, please fill in details):***

Yes No Are you in good health? ______
Yes No Do you have a history of a major illness? ______
Yes No Have you had any operations or been hospitalized? ______
Yes No Have you ever been involved in a serious accident? ______
Yes No Have you ever smoked or chewed tobacco? ______
Yes No Have seen a physician in the last 12 months? Why? ______
Yes No Are you taking any prescription and/or over-the-counter medication? ______
Yes No Are you allergic to any medication or substance (including latex or metals)? ______
Yes No Have any tonsils or adenoids been removed? ______

***Female Patients only:***

Yes No Are you pregnant? ______
Yes No Are you nursing? ______

***Children only:***

Yes No Has the patient reached puberty? ______
Yes No Has the patient's menstruation begun (girls)? ______
Yes No Has the patient's voice changed (boys)? ______

***Please circle any of the medical conditions below that you have had or currently have:***

Abnormal bleeding/Hemophilia
Anemia
Arthritis
Asthma
Bone Disorders
Congenital Heart Defect
Diabetes
Dizziness
Epilepsy/Convulsions/Seizures
Glaucoma
Kidney Disease
Leukemia
Hay Fever/Allergies
Heart Attack/Stroke
Heart Murmur
Heart Problems
Hepatitis/Jaundice
Herpes/Cold Sores
High/Low Blood Pressure
HIV+ / Aids
Liver Disease
Lung/Respiratory Problems
Migraines/Severe Headaches
Nervous Disorders
Pneumonia
Prolonged Bleeding
Psychiatric Problems
Radiation/Chemotherapy
Rheumatic/Scarlet Fever
Sexually Transmitted Disease
Sinus Problems
Stomach Trouble/Ulcers
Thyroid Problems
Tuberculosis

Are there any medical conditions we have not discussed that you feel we should be aware of?

______________________________

## DENTAL HISTORY

General Dentist ______________________________ Date of last visit ______________
What are the main concerns that you would like Orthodontics to address? ______

Yes No Have you ever had or been evaluated for Orthodontic treatment? ______
Yes No Are you presently in any dental pain? ______
Yes No Have you ever experienced any unfavorable reaction to dentistry? ______
Yes No Have you ever lost or chipped any teeth? ______
Yes No Have you ever been informed of any missing or extra teeth? ______
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 your gums bleed when you brush? ______
Yes No Are you aware of your jaw joint clicking or popping (TMJ/TMD)? ______
Yes No Are you aware of clenching/grinding of your teeth? ______
Yes No Do you have "tension" headaches? ______
Yes No Have you ever experienced chronic ringing in your ears? ______
Yes No Do you have any type of thumb or tongue habit? ______
Yes No Do you have any speech problems? ______
Yes No Are you a mouth breather? ______
Yes No Has anyone in your family received orthodontic treatment? ______
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______
Yes No If the patient is under age 18, height of parents? Mom______ Dad______
Yes No Are you aware that some appointments will be during school/work hours? ______
Please list some hobbies or interests ______

### BENEFITS

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 have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Linda Huynh to perform a complete orthodontic evaluation.

Signature: ______________________________ Date: ______________