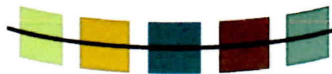
John S Woo DDS MS  Orthodontics

Patient's Name: Last ______________________ First ______________________ Middle ______________________

Sex: M F Birthdate: ______________ Age: ______________ (For children) Patient Lives with: Mom Dad Both

Marital status of parents: Single Married Divorced Remarried Other: ______________ E-mail: ______________________

Whom may we thank for referring you to our office?: ______________________ Patients Dentist: ______________________

## Responsible Party Information

Name: Last ______________________ First ______________________ Middle Initial ___ Relationship to Patient: ______________________

Address: ______________________ City: ______________________ Zip: ______________________

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________

Employer: ______________________ Occupation: ______________________

### Responsible Party's Spouse

NAME ______________________
First Last Middle

Address: ______________________

Home Phone: ______________ Cell Phone: ______________

Employer: ______________ Occupation: ______________

Relationship to Patient: ______________________

### Dental Insurance Information

Insurance Carrier Name: ______________ Group #: ______________

Subscriber's Name: ______________________
First Last Middle

Subscriber's ID #: ______________________

Subscriber's Date of Birth: ______________________

Subscriber's Employer: ______________________

## Medical History

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Fainting/Dizziness | ☐ | ☐ | Bone disorder | ☐ | ☐ | Neurological Disorders |
| ☐ | ☐ | Blood Pressure | ☐ | ☐ | Asthma | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Heart trouble | ☐ | ☐ | Epilepsy | ☐ | ☐ | Liver (Hepatitis) |
| ☐ | ☐ | Prolonged bleeding | ☐ | ☐ | Thyroid | ☐ | ☐ | Positive HIV Virus (AIDS) |
| ☐ | ☐ | Rheumatic fever | ☐ | ☐ | Kidneys | ☐ | ☐ | Arthritis of any kind |

Is there any other medical problem (or history of) that we should be aware of? ______________________

List any drug allergies or drug sensitivities ______________________

List any drug/medications now being taken ______________________

Are you allergic or sensitive to Latex? ______________________

## Dental History

| | Yes | No |
|---|---|---|
| Have there been any injuries to the teeth, mouth or jaws? | ☐ | ☐ |
| Thumb or finger sucking? Until what age? ______________ | ☐ | ☐ |
| Are any teeth especially sensitive? | ☐ | ☐ |
| Do the jaw joints make noise (clicking, popping or grating sounds)? | ☐ | ☐ |
| Do the jaws ever "lock" or get stuck? | ☐ | ☐ |
| Is there pain in front of, behind, or in your ears? | ☐ | ☐ |
| Is there difficulty when chewing or opening wide? | ☐ | ☐ |
| Is there tension or spasms in the head or neck? | ☐ | ☐ |
| Is stress or nervous tension affecting this problem? | ☐ | ☐ |
| Are there headaches in the morning, noon or evening? | ☐ | ☐ |
| Have you had a previous orthodontic examination? | ☐ | ☐ |
| Last dental visit? ______________ Were X-rays taken? | ☐ | ☐ |

What are the primary concerns? ______________________

*I authorize John S Woo DDS MS to release any information including diagnosis, records of any treatment, examination rendered to my child or me during this period of such dental care to third party payors and/or other health practitioners. I give release for the office to use photographs and the first initial or name of my child or self for office bulletin displays and/or office websites. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made.*

Signature ______________________ Date: ______________