Sebastopol Orthodontics

Dr. John S. Woo

Patient's Name: Last First Middle

What is your appointment reminder preference? Email Phone

Sex: M F Birthdate: Age: (For Children) Patient lives with: Mom Dad Both

Please list your sports and hobbies:

Marital Status of parents: Single Married Divorced Remarried Other

Whom may we thank for referring you to our office? Patient's Dentist:

Responsible Party Information

Name: Last First Middle

Address: City Zip

Home Phone Cell Phone Work Phone

Employer Occupation

Responsible Party's Spouse

Name: Last First Middle

Address:

Home Phone Cell Phone

Employer Occupation

Relationship to Patient:

Dental Insurance Information

Insurance Carrier's Name Group#

Subscriber's Full Name:

Subscriber's ID#

Subscriber's Date of Birth:

Subscriber's Employer

Medical History

Yes	No		Yes	No		Yes	No	
		Fainting/Dizziness			Sleep Apnea			Neurological Disorders
		Blood Pressure			Bone disorder			Diabetes
		Heart Trouble			Asthma			Liver (Hepatitus)
		Prolonged bleeding			Epilepsy			Positive HIV Virus (AIDS)
		Rheumatic Fever			Thyroid			Arthritis of any kind
		Snoring			Kidneys			

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

Have there been any injuries to the teeth, mouth or jaws?

Thumb of finger sucking? Until what age?

Are any teeth especially sensitive?

Do the jaw joints make noise (clicking, popping or grating sounds?)

Is there pain in front of, behind, or in your ears?

Is there dificulty 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 Dr. John S. Woo, Dr. Marc deBerardinis and Dr. Wilson Ng to release any information, including diagnosis, records of 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 my photographs and the first intial 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

Please type your name here. Typing your name here will serve as your E-signature.