

PAUL Y. LEE, D.D.S.

Practice Limited to Orthodontics

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Patient Registration
History-Child

PATIENT'S NAME _____ BIRTH DATE ___/___/___ FEMALE MALE
 SCHOOL _____ GRADE _____ AGE _____ HOBBIES _____
 HOME ADDRESS _____
 _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)
 HOME PHONE _____ E-MAIL _____ CELL/PAGER _____
 MOTHER'S NAME _____ FATHER'S NAME _____
 MOTHER'S EMPLOYER _____ FATHER'S EMPLOYER _____
 MOTHER'S WORK PH.# _____ FATHER'S WORK PH.# _____
 OCCUPATION _____ SSN _____ OCCUPATION _____ SSN _____
 SIBLINGS _____ REFERRED BY WHOM _____
 BILLING NAME _____ RELATIONSHIP TO PATIENT _____
 BILLING ADDRESS _____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____ DATE OF LAST VISIT _____
 ADDRESS _____ DATE OF LAST X-RAY _____
 DATE OF LAST CLEANING _____ ANY PENDING WORK? _____
 WHAT IS YOUR MAJOR CONCERN ABOUT YOUR TEETH? _____

	YES	NO		YES	NO
Have you ever had previous orthodontic consultation or treatment?	___	___	Do you grind or clench your teeth?	___	___
Have you ever been informed of any extra or missing teeth?	___	___	Do you have pain or clicking of the	___	___
Have any permanent teeth been removed by extraction?	___	___	jaw joint? L/R	___	___
Have any teeth been injured or chipped due to an accident?	___	___	Do you ever have pain the face	___	___
Has any family member had orthodontic treatment?	___	___	or ear? L/R	___	___
Who? _____	___	___	Have you ever had severe jaw or	___	___
Do you now suck your thumb, finger or nail biting or other habit?	___	___	head injury	___	___
Do your gums bleed on brushing or flossing?	___	___	Do you breath predominantly through the	___	___
Are you concerned about the appearance of your teeth?	___	___	mouth?	___	___
Do you have any speech problem?	___	___	Do you want your teeth straightened?	___	___
Are there any other dental/orthodontic problems we should be aware of?	___	___	IF YES, PLEASE EXPLAIN _____	___	___

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT _____
 ADDRESS _____ MED ID# _____

	YES	NO		YES	NO	YES	NO	
Have you under gone a physical exam in the past year?	___	___	Have you ever been diagnosed or treated for the following?					
Are you presently under a physician's care?	___	___		YES	NO	YES	NO	
Have you ever had a major surgery?	___	___	Heart Problems	___	___	Hepatitis	___	___
Have you ever been hospitalized?	___	___	Kidney Problems	___	___	Rheumatic Fever	___	___
Are you taking any pills, medications or drugs?	___	___	Lung Problems	___	___	Emotional Problems	___	___
Are you allergic to novocaine or penicillin?	___	___	Liver Problems	___	___	Malignancies	___	___
Have you ever had an unusual reaction to any medications?	___	___	Allergies	___	___	Endocrine Problems	___	___
Have you had tonsils and/or adenoids removed?	___	___	Diabetes	___	___	Bone	___	___
Do you have fainting or dizzy spells?	___	___	Epilepsy	___	___	Prolonged Bleeding	___	___
Do you have a too high or low blood pressure?	___	___	Anemia	___	___	Tuberculosis	___	___
Are there any medical problems we should be aware of? IF YES, PLEASE EXPLAIN _____	___	___	Arthritis	___	___	Asthma	___	___

(Please see next page)

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

ADDITIONAL INSURANCE

Name of insured _____

Name of Insured _____

Relationship to patient _____

Relationship to patient _____

Insurer's B-day _____ Soc. Sec.# _____

Insurer's B-day _____ Soc. Sec. # _____

Employer _____

Employer _____

Insurance Company _____

Insurance Company _____

Group # _____ Employee Cert.# _____

Group # _____ Employee Cert. # _____

Insurance Phone # _____

Insurance Phone # _____

Parent's Signature: _____

Date _____

