



**Dr. Richard Lee**  
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### PATIENT INFORMATION

Patient's Full Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
Siblings (name & age) \_\_\_\_\_  
Sports and/or Hobbies \_\_\_\_\_  
Attends School at \_\_\_\_\_ Grade \_\_\_\_\_

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### GUARDIAN INFORMATION

**Name of Mother or Guardian** \_\_\_\_\_  
Phone Number (if different than patient) \_\_\_\_\_ Cell \_\_\_\_\_  
Address (if different than patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email address \_\_\_\_\_

**Name of Father or Guardian** \_\_\_\_\_  
Phone Number (if different than patient) \_\_\_\_\_ Cell \_\_\_\_\_  
Address (if different than patient) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email address \_\_\_\_\_

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## INSURANCE INFORMATION

**Primary Dental Insurance** \_\_\_\_\_ ID Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

**Secondary Dental Insurance** \_\_\_\_\_ ID Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

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## MEDICAL INFORMATION

Who is the patient's physician? \_\_\_\_\_ Phone \_\_\_\_\_

Is the patient in overall good health? **Y N** If no, please explain:

Does the patient have any history of major illness? **Y N** If no, please explain:

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**Check any of the following for which the patient has been diagnosed or treated:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Bleeding abnormally |
| <input type="checkbox"/> Bone Disorders         | <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Chemo/radiation    | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Eating Disorder    | <input type="checkbox"/> Endocrine           |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Heart disease       |
| <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Lupus                  | <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Muscular Dystrophy     | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Nervous Disorder    |
| <input type="checkbox"/> Hepatitis, Type: _____ | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Transplants        | <input type="checkbox"/> Tuberculosis        |

Other: \_\_\_\_\_

Please list any surgeries/hospitalizations that the patient has had in the past year:

Please list any **allergies** to food, medication or metals:

Is the patient allergic to latex? **Y N** Allergic to nickel? **Y N**

Does the patient have trouble wearing jewelry? **Y N**

**Females only:** Are you pregnant? **Y N** Are you nursing? **Y N**

Please list any **medications** the patient is currently taking: \_\_\_\_\_

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## DENTAL INFORMATION

Who is the patient's dentist? \_\_\_\_\_ Phone \_\_\_\_\_

When was the patient's last dental appointment? \_\_\_\_\_

Please describe any injuries to the face, mouth, or teeth that the patient has had:

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**Please circle YES or NO for all questions below:**

- Y N Started teething very early or late?
  - Y N Baby teeth removed that were not loose?
  - Y N Congenitally missing teeth?
  - Y N Supernumerary (extra) teeth removed?
  - Y N Chipped or otherwise injured baby/permanent teeth?
  - Y N Jaw Fractures, cysts, or mouth infections? Describe above
  - Y N Sensitivity to hot/cold or teeth throb or ache?
  - Y N Bleeding gums, bad taste or mouth odor?
  - Y N Periodontal "gum problems"?
  - Y N Had periodontal "gum" treatment(s)?
  - Y N Root canals or "dead" teeth?
  - Y N Food impaction in between teeth?
  - Y N Frequent cold or canker sores?
  - Y N History of speech problems?
  - Y N Have you ever sucked a thumb or finger/s?
  - Y N Breath through his/her mouth while awake?
  - Y N Breath through his/her mouth while asleep?
  - Y N Grind teeth at night?
  - Y N Jaw clenching, clicking, or locking?
  - Y N Any teeth irritating the cheek, lip, tongue, or palate?
  - Y N Been treated for "TMJ" or "TMD"
  - Y N Aware or concerned about over or under developed jaw relationships?
  - Y N Any wisdom tooth problems?
  - Y N Had any serious trouble with previous dental treatment? If yes, please describe briefly:
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I have read and understand the questions above. I will not hold Dr. Richard Lee, Patuxent Orthodontics, or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record/dental status, I understand that it is my responsibility to inform Patuxent Orthodontics as soon as I can while in treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(or Guardian if patient is under 18 years old)*