RYE FAMILY ORTHODONTICS

Leon Su, DDS, MS

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Who can we thank for referring you to our office?_____

Name of patient_____ Birth Date_____

Mother first and last name _____

Father first and last name _____

Home Address _____Home Phone_____

Patients School and grade level _____

Person Responsible for account _____ Relationship_____

Address_____ Home Phone_____

Occupation _____Employer _____

Cell Phone _____

Email:_____

Is patient covered by insurance for Orthodontic treatment? ☐ Yes ☐ No

Insurance Company _____

Insurance Address _____

Member ID _____ Group # _____

Name of Emergency Contact _____

Home Phone _____Work Phone _____Cell Phone _____

Relationship _____ Address _____

Dentist Name _____

Phone _____Address_____

Pediatrician Name _____

Phone _____Address _____

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Patient Medical History

	Yes	No
Has the patient recently taken any xrays or CT scans?	☐	☐
Is the patient in good health?	☐	☐
Date of last exam by pediatrician? _____		
Does the patient have a history of major illness?	☐	☐
Has the patient ever been hospitalized? If Yes please explain_____ _____	☐	☐
Is patient taking any medication including Vitamins or Supplements? If Yes, please list:_____ _____	☐	☐
Does patient have any allergies? If yes, please list:_____ _____	☐	☐
Has patient ever had a blood transfusion?	☐	☐
Does patient have a tendency to sore throats?	☐	☐
Does patient bruise easily?	☐	☐
Has patient's tonsils and/or adenoids been removed?	☐	☐

	Yes	No
Does patient have chronic ear pain or infections?	☐	☐
Does patient snore when sleeping?	☐	☐
Does patient have chewing or swallowing difficulty?	☐	☐
Does patient have any of the following?		
Asthma	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Bleeding disorders	☐	☐
Bone disorders	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Emotional problems or anxiety	☐	☐
Fainting	☐	☐
Heart Disease	☐	☐
Tuberculosis	☐	☐
Hepatitis	☐	☐
Speech or hearing disorder	☐	☐
Often fatigued	☐	☐
Frequent headaches	☐	☐
Sinus trouble	☐	☐
Endocrine problems	☐	☐
Any medical condition not listed? _____		

Patient Dental History

	Yes	No
Date of patient's last dental exam or treatment? _____		
Has the patient had any problems associated with previous dental treatment?	☐	☐
Have there been any injuries to patient's face, mouth or teeth?	☐	☐
Has there been any treatment for problems of the jaw joint or facial muscles?	☐	☐
Has patient ever sucked a thumb, pacifier or fingers? Until what age? _____	☐	☐
Does patient bite or suck on their lips?	☐	☐
Does patient have any speech problems?	☐	☐

	Yes	No
Is patient a mouth breather?	☐	☐
Has patient had previous orthodontic treatment or an orthodontic consultation? If yes, please explain _____ _____	☐	☐
Has either parent ever had orthodontic treatment?	☐	☐
Has either parent had periodontal disease?	☐	☐
Does patient use a sports mouth guard?	☐	☐
List any musical instruments played? _____		

Print Parent or Guardian Name _____

X_____ Date_____
Signature of Patient or Guardian

Signature of Doctor _____