TYSONS ORTHODONTIC CARE
Phu T. Le, DDS

WELCOME

We would like to welcome you to our office. In an effort to provide you with the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Name _____ _____ _____ _____ Sex
Last First Middle Age

Address _____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail_____ Home Phone _____ Social Security #_____
MM/DD/YYYY ###-##-####

Whom may we thank for referring you to our office: _____

General Dentist's Information

Dentist Name _____ Address_____ Phone#_____ Last Visit _____
City, State

Practice Name _____

Parents Information

Parent/Guardian 1

Name _____ _____ _____ _____ _____
Last First Middle Marital Status Relationship to Patient

Address_____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail_____ Social Security #_____
MM/DD/YYYY

Home Phone _____ Cell Phone _____ Work Phone_____ Ext _____

Employer_____ Occupation_____ No. Years Employed _____

Parent/Guardian 2

Name _____ _____ _____ _____ _____
Last First Middle Marital Status Relationship to Patient

Address _____ _____ _____ _____
Street City State Zip

Birthdate _____ E-mail_____ Social Security #_____
MM/DD/YYYY

Home Phone _____ Cell Phone _____ Work Phone_____ Ext _____

Employer_____ Occupation_____ No. Years Employed _____

Insurance Information

Policy Holder's Name_____ Policy Holder's Employer_____

Policy Holder's Date of Birth _____ Insurance Company _____

ID Number_____ Group ID_____

Getting to Know You!

School _____ Grade_____

Brothers/Sisters (include age):_____

Activities/Hobbies/Sports: _____

Medical History

Medical Physician_____ Phone # _____ Last Visit _____

Circle All that Apply:
Is the child currently under the care of a physician? Yes/No If Yes, explain: _____.

Has Puberty begun? Yes/No Has menstruation (period) begun? Yes/No n/a

Have the patient's tonsils or adenoids been removed? Yes/No

Has the patient ever experienced jaw joint pain/discomfort (TMJ/TMD)? Yes/No

Does the patient have any missing or extra permanent teeth? Yes/No

Has the patient had any injury to: Teeth Mouth Chin

Does the patient have speech problems? Y/N

Check the following:
Does the patient have/had any history of the following __ HIV/AIDS/STD's __ TB: Inactive /Active __Hepatitis Type: B/C

__N/A

Has the patient ever had any of the following habits: __Lip Sucking/biting __Nail biting __Prolonged bottle/Pacifier

__Clenching/Grinding __Mouth Breather __Tongue Thrusting

__Thumb/Finger Sucking

List all the following that apply:
Is he/she allergic to any of the following (Circle all that apply) : Latex Metals Plastics

Allergies:	Medications:	Medical Conditions:

Has the patient ever been evaluated for orthodontic treatment? Yes/No

What are the main concerns that you would like orthodontics to accomplish? _____

Signature

I understand that the following information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Parent/Guardian Printed Name:_____

Parent/ Guardian Signature: _____ Date:_____