REBECCA ORTENZIO LEE ORTHODONTICS

Rebecca Ortenzio Lee, DDS, MSD
Board Certified Orthodontist
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Date_____

Patient Information

Patient's Name_____ Sex ( ) Male ( ) Female
Last First Middle
Address_____
Street City State Zip Apt.#
Home Phone( )_____Birthdate_____Age_____SSN_____
E-Mail Address _____
School_____Grade_____
Names and Ages of Brothers/Sisters_____
Has any family member had orthodontic treatment?_____
Whom may we thank for referring you?_____

Responsible Party/Primary Custodial Parent /Guardian Information

Name_____Marital Status_____
Last First Middle
Residence_____
Street City State Zip Apt.#
Home Phone( )_____Work Phone( )_____Cell Phone( )_____
E-Mail Address_____
How long at this address?_____ Previous Address (if <3 years)_____
Street City State Zip
Employer_____Occupation_____No.Years Employed_____
Social Security#_____Birthdate_____Relationship to Patient_____

Spouse's Name_____Relationship to Patient_____
Last First Middle
Employer_____Occupation_____No.Years Employed_____
Social Security#_____Birthdate_____Work Phone( )_____

Dental Insurance Information

Insured's Name_____Home Phone( )_____
Insured's SSN_____Birthdate_____Relationship to Patient_____
Insured's Mailing Address_____
Insured's Employer_____Employer's Phone( )_____
Insurance Company_____Group Number_____Local Number_____
Insurance Co. Address_____Ins. Co. Phone( )_____
Do you have dual coverage? Yes or No If yes, please complete below:
Insured's Name_____Home Phone( )_____
Insured's SSN_____Birthdate_____Relationship to Patient_____
Insured's Mailing Address_____
Insured's Employer_____Employer's Phone( )_____
Insurance Company_____Group Number_____Local Number_____
Insurance Co. Address_____Ins. Co. Phone( )_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent/Guardian signature if minor)_____

PATIENT INFORMATION

DENTIST_____ **LAST SEEN**_____

PHYSICIAN_____ **LAST SEEN**_____

MUSICAL INSTRUMENT_____

Do you (the patient) have any of the following habits?

Y/N	Thumb/Finger Sucking
Y/N	Clenching/Grinding Teeth
Y/N	Mouth Breather
Y/N	Speech Problems
Y/N	Nail Biting
Y/N	Tongue Thrust
Y/N	Does your jaw ever get "stuck, locked, or go out"?
Y/N	Do you hear noises from the jaw joint, including clicking/popping?
Y/N	Do you have pain in or about the ears or cheeks?
Y/N	Do you have pain when chewing or yawning?
Y/N	Does your bite feel uncomfortable?

Current Health: Good_____ Fair_____ Poor_____
List all medications/drugs currently taking, including birth control_____
_____

List all allergies_____

Are you currently under the care of a physician? If yes, please give reason_____
_____

Do you use tobacco products? _____

Do you (the patient) have a history of any of the following medical problems?

Y/N	Heart Murmur/Defects	Y/N	Convulsions/Epilepsy
Y/N	Diabetes	Y/N	Hearing Impairment
Y/N	Cancer	Y/N	Kidney/Liver Problems
Y/N	Blood Transfusion	Y/N	Fainting/Dizziness
Y/N	HIV/ Aids	Y/N	Neurological
Y/N	Hepatitis	Y/N	Lyme Disease
Y/N	Mitral Valve Prolaspe	Y/N	Handicap/Disabilities
Y/N	Hemophilia	Y/N	Dependency on Drugs/Alcohol
Y/N	Asthma	Y/N	Tuberculosis
Y/N	Rheumatic Fever	Y/N	Hypertension

Y/N Has there been any injuries to the face, mouth, chin, or jaw?
Y/N Have you been informed of any missing teeth or extra teeth?
Y/N Have you ever been evaluated for orthodontic treatment?