PAUL Y. LEE, D.D.S.

Patient Registration
History-Adult

Practice Limited to Orthodontics
* 10251 Torre Avenue Ste. #118 Cupertino, CA 95014 (408) 996-1204
* 995 Montague Expressway Ste. #117 Milpitas, CA 95035 (408) 946-0766

MR. ___ MRS.___ MALE ___ FEMALE ___
MS. ___ DR. ___
NAME_____HOME PHONE_____
FIRST MIDDLE LAST
HOME ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)
EMPLOYER _____BUSINESS PHONE _____
OCCUPATION_____ E-MAIL_____CELL_____
ADDRESS_____
SOC. SEC. # : _____ DATE OF BIRTH: _____ AGE:_____
MARRIED Y/N SPOUSE NAME_____ REFERRED BY: _____

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 have finger or nail biting or other habit?	___	___	head injury	___	___
Do your gums bleed on brushing or flossing?	___	___	Do you breath predominantly through		
Do you have any speech problem?	___	___	the mouth?	___	___

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
Have you under gone a physical exam in the past year?	___	___
Are you presently under a physician's care?	___	___
Have you ever had a major surgery?	___	___
Have you ever been hospitalized?	___	___
Are you taking any pills, medications or drugs?	___	___
Are you allergic to novocaine or penicillin?	___	___
Have you ever had an unusual reaction to any medications?	___	___
Have you had tonsils and/or adenoids removed?	___	___
Do you have fainting or dizzy spells?	___	___
Do you have a too high or low blood pressure?	___	___

Have you ever been diagnosed or treated for the following?

	YES	NO		YES	NO
Heart Problems	___	___	Hepatitis	___	___
Kidney Problems	___	___	Rheumatic Fever	___	___
Lung Problems	___	___	Emotional Problems	___	___
Liver Problems	___	___	Malignancies	___	___
Allergies	___	___	Endocrine Problems	___	___
Diabetes	___	___	Bone	___	___
Epilepsy	___	___	Prolonged Bleeding	___	___
Anemia	___	___	Tubercolosis	___	___
Arthritis	___	___	Asthma	___	___

Are there any other medical problems we should be aware of? _____IF YES, PLEASE EXPLAIN_____
_____

(Please see next page)

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of insured _____

Relationship to patient_____

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

Employer _____

Insurance Company_____

Group #_____Employee Cert.#_____

Insurance Phone #_____
_____

ADDITIONAL INSURANCE

Name of Insured_____

Relationship to patient_____

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

Employer_____

Insurance Company_____

Group # _____Employee Cert. #_____

Insurance Phone #

Patient's Signature:_____ Date:_____