Welcome to Our Office!

Dr. Angelina Y.C. Loo Inc.
Dr. Edwin H.K. Yen
www.bracedinbc.com

PATIENT PERSONAL INFORMATION

Name _____/_____ Date_____
Last First

Age _____ Sex _____ Date of Birth _____/_____/_____ Best Email_____
Month Day Year

Address _____
Street City Postal Code

Home Phone _____ Cell Phone _____

School_____ Grade_____

Mother's Name _____ Email _____

Home #_____ Cell #_____ Work # _____

Address (If **not** the same as patient's) _____

Father's Name _____ Email _____

Home #_____ Cell #_____ Work # _____

Address (If **not** the same as patient's) _____

If responsible party is other than the patient's parents, please give information: Or check if not applicable ☐

Name _____Relationship to Patient _____

Address _____ Email _____

Home #_____ Cell #_____ Work # _____

Patient's Family Dentist _____

Patient's Family Physician _____

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

DENTAL INSURANCE INFORMATION

Name of Insurance # 1 _____

Name of Policyholder_____

Group Number _____ Identification Number_____

Birthdate of Policy-holder _____ Employed By_____

Name of Insurance # 2 _____

Name of Policyholder_____

Group Number _____ Identification Number_____

Birthdate of Policy-holder _____ Employed By_____

MEDICAL HISTORY (Patient had or has the following medical conditions:)

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Persistent Headache	☐	☐
Heart Murmur	☐	☐	Neck Pains	☐	☐
High Blood Pressure	☐	☐	Nerve or Brain Disease	☐	☐
Heart Attack/Stroke	☐	☐	Migraine	☐	☐
Blood Vessel Disease	☐	☐	Epilepsy	☐	☐
Blood Disorder	☐	☐	Mental Health Concerns	☐	☐
AIDS/HIV Infection	☐	☐	Bone Disorders	☐	☐
Hepatitis	☐	☐	Arthritis (Any type)	☐	☐
Diabetes	☐	☐	Sleep Apnea	☐	☐
Ulcers	☐	☐	Ear Disorder	☐	☐
Herpes (Any type)	☐	☐	Sinus Infection	☐	☐
Psoriasis	☐	☐	Swollen Glands	☐	☐
Cancer	☐	☐	Allergies	☐	☐

Comments _____

Please list any other significant information about the patient's medical history:

_____

_____

_____

Yes	No	
☐	☐	Is the patient under a physician's care at the present? If yes, please describe _____
		_____
☐	☐	Is the patient presently, or has the patient ever been, under the care of a psychiatrist or psychologist? If yes, please describe _____
☐	☐	Is the patient currently taking any medication? If yes, please list_____
☐	☐	Is the patient allergic to any medications? (Eg: Aspirin, Penicillin, Etc.) If yes, please list_____
		_____
☐	☐	Has the patient ever had a general anesthesia? When and why?_____

DENTAL HISTORY

☐	☐	Does any of the patient's teeth hurt? If yes: *Upper Right* ☐ *Upper Left* ☐ *Lower Right* ☐ *Lower Left* ☐
☐	☐	Has any of the patient's wisdom teeth been removed? How many? _____
☐	☐	Has the patient had treatments for a periodontal disease (gum disease)? If yes, please describe _____
		_____
☐	☐	Has the patient had previous orthodontic treatments (braces or retainers)? If yes, When?_____ Previous Orthodontist _____
☐	☐	Has the patient had previous injuries to his/her mouth or teeth? If yes, describe _____
☐	☐	Has the patient been fallen and hurt his/her chin, or received a blow to his/her jaws? If yes, describe _____
		_____
☐	☐	Has the patient had previous surgeries in the head or neck area? If yes, describe _____
☐	☐	Does the patient grind his/her teeth? If yes, while sleeping ☐ Under stress ☐ Other _____
☐	☐	Do the patient's jaw muscles ever feel tired? If yes, when _____
☐	☐	Does the patient ever notice soreness, lightness or pain in the muscles around the jaws and face? Describe: __
		_____
☐	☐	Does it hurt when the patient chews? If yes, where does it hurt? _____
☐	☐	Does the patient hear clicking (popping) or grating sounds in his/her jaw joints? If yes, please describe

	Right	Left	Since when_____	During what activity _____
Clicking	☐	☐		
Grating	☐	☐		

Did these joint sounds begin gradually or suddenly? Gradually ☐ Suddenly ☐

☐	☐	Any specific events that started the joint sounds? If yes, describe _____

Yes **No**

□ □ Has the patient had difficulties in opening or closing his/her jaws? If yes, describe _____
□ □ Has the patient's jaws ever been "locked" when closed? If yes, describe _____
□ □ Has the patient's jaws ever been "locked" when opened? If yes, describe _____
□ □ Does the patient have pain in his/her jaw joints? If yes, right □ left □ Since when? _____
□ □ During what activity? _____ Describe nature of pain _____
What increases the pain? _____ What decreases the pain? _____

Does the patient have any of the following habits?

Yes **No**

□ □ Finger/Thumb-sucking
□ □ Lip Biting
□ □ Nail Biting
□ □ Gum Chewing
□ □ Ice Chewing

GROWTH AND DEVELOPMENT:

Patient's present height _____
Expected height of patient _____
Parents' heights _____

Yes **No**

□ □ Has patient reached adolescent growth?
□ □ Girls – Has monthly cycle started yet? If so, at what age? _____
□ □ Boys – Has voice changed yet? If so, at what age? _____
□ □ Is the patient adopted? Does the patient know? Yes □ No □
□ □ Does the patient have any learning disabilities? If yes, explain _____
□ □ Has any other member of the family had orthodontic treatment? Name _____
□ □ Has any other member of the family been a patient in this office? Name _____
□ □ Are there other children in the family? Names and Ages _____

Please describe why you sought this consultation _____

_____

_____

Any additional information concerning the patient would be appreciated. We are also interested in the patient's special interests and hobbies! _____

_____

Questions, Comments, and Concerns? Please share your thoughts with us _____

_____

_____

_____

_____

I, the undersigned, certify that I have read and understood the above medical and dental information, have reviewed it, and found it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this to the office. I also give my permission for a clinical examination.

_____ _____

Signature of Responsible Adult Date