**Haesin Sabina Jung, D.D.S., P.C.**
**Family Orthodontics**

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## Patient's Clinical History/ Family Information : CONFIDENTIAL

(Please Complete in ink)

**NAME**____________________ BIRTHDATE______________ HOME PHONE______________
ADDRESS____________________ CITY______________ STATE________ ZIP__________
SCHOOL____________________ GRADE______________
Best Phone # to Call for Appointments (**DURING BUSINESS HOURS**) ______________ E-mail Address______________
WHOM MAY WE THANK FOR REFERRING YOU?____________________________

**FATHER'S NAME**____________________ D.O.B.__________ S.S.#______________
Last First **(for accounting purposes only)**
MARITAL STATUS:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried
HOME ADDRESS____________________ HOME PHONE______________
EMPLOYED BY____________________ OCCUPATION______________ POSITION______________
BUSINESS ADDRESS____________________ WORK PHONE______________

**MOTHER'S NAME**____________________ D.O.B.__________ S.S.#______________
Last First **(for accounting purposes only)**
MARITAL STATUS:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried
HOME ADDRESS____________________ HOME PHONE______________
EMPLOYED BY____________________ OCCUPATION______________ POSITION______________
BUSINESS ADDRESS____________________ WORK PHONE______________

## INSURANCE INFORMATION

NAME OF INSURED____________________ RELATIONSHIP TO PATIENT______________
BIRTHDATE______________ SOCIAL SECURITY NUMBER______________ DATE EMPLOYED______________
NAME OF EMPLOYER ____________________ WORK PHONE______________
ADDRESS OF EMPLOYER ______________ CITY______________ STATE__________ ZIP __________
INSURANCE COMPANY______________ GROUP #______________ UNION OR LOCAL # ______________
INS. CO. ADDRESS______________ CITY______________ STATE__________ ZIP __________

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____ YES_____ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED____________________ RELATIONSHIP TO PATIENT______________
BIRTHDATE______________ SOCIAL SECURITY NUMBER______________ DATE EMPLOYED______________
NAME OF EMPLOYER ____________________ WORK PHONE______________
ADDRESS OF EMPLOYER ______________ CITY______________ STATE__________ ZIP __________
INSURANCE COMPANY______________ GROUP #______________ UNION OR LOCAL # ______________
INS. CO. ADDRESS______________ CITY______________ STATE__________ ZIP __________

PATIENT'S NAME________________________________________ TODAY'S DATE____________________

PATIENT'S FAMILY DENTIST________________________________________________

PATIENT'S FAMILY PHYSICIAN______________________________________________

## PATIENT MEDICAL HISTORY

| | | YES | NO |
|---|---|---|---|
| 1. | Are you under medical treatment now? | ___ | ___ |
| 2. | Have you ever been hospitalized for any surgical operation or serious illness? | ___ | ___ |
| 3. | Are you taking any medication(s) including Non-prescription medicine? | ___ | ___ |
| | If yes, what medication(s) are you taking?____________________ | | |
| 4. | Do you use tobacco? | ___ | ___ |
| 5. | Do you use alcohol, cocaine or other drugs? | ___ | ___ |
| 6. | Are you wearing contact lenses? | ___ | ___ |

7. Are you allergic to or have you had any reactions to medications? (Eg: aspirin, penicillin, sulfa drugs, etc.) If yes,what?________________

| 8. Women ONLY: | Yes | No |
|---|---|---|
| a) Are you pregnant or think you may be pregnant? | ___ | ___ |
| b) Are you nursing? | ___ | ___ |
| c) Are you taking birth control pills? | ___ | ___ |

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

8. Do you have or have you had any of the following?

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ( ) | ( ) | High blood pressure | ( ) | ( ) | Heart Disease | ( ) | ( ) | Chest Pains |
| ( ) | ( ) | Heart Attack | ( ) | ( ) | Cardiac Pace maker | ( ) | ( ) | Easily Winded |
| ( ) | ( ) | Rheumatic Fever | ( ) | ( ) | Heart Murmur | ( ) | ( ) | Stroke |
| ( ) | ( ) | Swollen Ankles | ( ) | ( ) | Angina | ( ) | ( ) | Hay Fever / Allergies |
| ( ) | ( ) | Fainting/ Seizures | ( ) | ( ) | Frequently Tired | ( ) | ( ) | Tuberculosis |
| ( ) | ( ) | Asthma | ( ) | ( ) | Anemia | ( ) | ( ) | Radiation Therapy |
| ( ) | ( ) | Low Blood Pressure | ( ) | ( ) | Emphysema | ( ) | ( ) | Glaucoma |
| ( ) | ( ) | Epilepsy/ Convulsions | ( ) | ( ) | Cancer | ( ) | ( ) | Recent Weight Loss |
| ( ) | ( ) | Leukemia | ( ) | ( ) | Arthritis | ( ) | ( ) | Liver Disease |
| ( ) | ( ) | Diabetes | ( ) | ( ) | Joint Replacement or implant | ( ) | ( ) | Heart Trouble |
| ( ) | ( ) | Kidney Diseases | ( ) | ( ) | Hepatitis/ Jaundice | ( ) | ( ) | Respiratory Problems |
| ( ) | ( ) | AIDS or HIV Infection | ( ) | ( ) | STD | ( ) | ( ) | Other_____________ |
| ( ) | ( ) | Thyroid Problem | ( ) | ( ) | Stomach Troubles/ Ulcers | | | |

## PATIENT DENTAL HISTORY

| | YES | NO |
|---|---|---|
| 1. Do your gums bleed while brushing or flossing? | ___ | ___ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ___ | ___ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ___ | ___ |
| 4. Do you feel pain to any of your teeth? | ___ | ___ |
| 5. Do you have any sores or lumps in or near your mouth? | ___ | ___ |
| 6. Have you had any head, neck, or jaw injuries? | ___ | ___ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| a) Clicking | ___ | ___ |
| b) Pain (joint, ear, side of face)? | ___ | ___ |
| c) Difficulty in opening or closing? | ___ | ___ |
| d) Difficulty in chewing? | ___ | ___ |

| | YES | NO |
|---|---|---|
| 8. Do you have frequent headaches? | ___ | ___ |
| 9. Do you clench or grind your teeth? | ___ | ___ |
| 10. Do you bite your lips or cheeks ? | ___ | ___ |
| 11. Have any wisdom teeth been removed? How many? | ___ | ___ |
| 12. Have you had any orthodontic work? | ___ | ___ |
| If yes, when________________________________ | | |
| If yes, doctor's name________________________ | | |
| 13. Have you ever had treatment for a periodontal disease (gum disease)? | ___ | ___ |
| 14. Have your jaws ever "locked" CLOSED? If yes, describe__________________ | ___ | ___ |
| 15. Have your jaws "locked" wide OPEN? If yes, describe__________________ | | |

## GROWTH AND DEVELOPMENT

| YES | NO | |
|---|---|---|
| ___ | ___ | Girls- Has monthly cycle started yet? If so, when______________________ |
| ___ | ___ | Boys- Has voice changed yet? If so, when______________________ |
| ___ | ___ | Are there any learning disabilities? If yes, explain______________________ |
| ___ | ___ | Has any other member of the family had orthodontic treatment?__________________ |
| ___ | ___ | Has any other member of the family been a patient in this office? Name:________________ |

**Please describe why you sought this consultation**______________________________________

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

______________________________________ ______________________

(Signature of Responsible Adult) Date

**Doctor'sNotes**______________________________________________________________

________________________________________________________________________

________________________________________________________________________