JESSICA CHUNG-LEVY, D.D.S. ***Specialist in Orthodontics and Dentofacial Orthopedics***
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Today's Date ______/______/_______

Name:____ Male____ Female___
First M.I. Last

SS#:__________-__________-__________ Date of birth:_____/_____/_____ Age:_______
month date year

Home Address:____
street town state zip code

Home#: ( )__________-__________________ Mobile#: ( )__________-__________________

Work#: ( )__________-________________ext:____ E-mail:______________________________

I prefer to be called at my: work / home / mobile phone number. Best times to call: __________________.

Occupation:__________________________________ Employer:__________________________

General Dentist:______________________________________ Phone#: ( )______-_________

Address:____ Last Visit Date:_____/_____/_____

Spouse/ Partner Information

His/her Name: ____ Date of birth:_____/_____/______

Employer:___________________________________ Work#: ( )______-_________ ext:________

Person Responsible for Account: ____________________________ Relation: ___________________

SS#:__________-__________-__________(Enter only if you would like us to submit an insurance claim for you)

Please provide dental insurance information if you would like us to file a dental claim on your behalf.

Primary Dental Ins. Co.:______________ Member's name & date of birth:______________________Group #:__________

Secondary Dental Ins. Co.:_____________ Member's name & date of birth:______________________Group #:__________

Whom may we thank for referring you? ____

Other family members/friends seen by us: ____

CONTINUED ON THE BACK

Medical History

Physician:________________________________ Phone#: (   )_______-_________ Date of Last Visit:_________________

Your current physical health is: Good____ Fair____ Poor____

Are you currently under the care of a physician? Yes__ No__ Please explain:_______________________________________

Are you taking any prescription/over-the-counter medication? Yes____ No____

Please list each one: ____

For Woman: Are you taking birth control pills? Yes__ No__ Pregnant? Yes__ No__ Week#: ______ Nursing? Yes__ No__

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y__ N__	Heart Surgery/Pacemaker	Y__ N__
Anemia/Radiation Treatment	Y__ N__	Hemophilia	Y__ N__
Artificial Bones/Joints/Valves	Y__ N__	Hepatitis	Y__ N__
Arthritis	Y__ N__	High/Low Blood Pressure	Y__ N__
Asthma	Y__ N__	HIV+/AIDS	Y__ N__
Blood Transfusion	Y__ N__	Hospitalized for Any Reason	Y__ N__
Cancer/Chemotherapy	Y__ N__	Kidney Problems	Y__ N__
Diabetes/Tuberculosis (TB)	Y__ N__	Migraines	Y__ N__
Difficulty Breathing	Y__ N__	Psychiatric Problems	Y__ N__
Drug/Alcohol Abuse	Y__ N__	Rheumatic/Scarlet Fever	Y__ N__
Emphysema/Glaucoma	Y__ N__	Severe/Frequent Headache	Y__ N__
Epilepsy/Seizures/Fainting	Y__ N__	Shingles	Y__ N__
Fever Blisters/Herpes	Y__ N__	Sinus Problems	Y__ N__
Heart Attack/Stroke	Y__ N__	Ulcers/Colitis	Y__ N__
Heart Murmur/ Mitral Valve Prolapse	Y__ N__	Venereal Disease	Y__ N__
History of Cleft Palate/Lip	Y__ N__		

Please list any serious medical condition(s) that you have ever had: ____

Are you allergic to any of the following?

Aspirin	Y__ N__	Dental Anesthetics	Y__ N__	Penicillin	Y__ N__
Any Metals/Plastic	Y__ N__	Erythromycin	Y__ N__	Tetracycline	Y__ N__
Codeine	Y__ N__	Latex	Y__ N__	Other	Y__ N__

Please list any other drugs/materials that you are allergic to: ____

Dental History

Have you ever had or been evaluated for orthodontic treatment? Yes___ No___

Have you ever had a serious/difficult problem associated with any previous dental work? Yes___ No___

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes___ No___

Your current dental health is: Good__ Fair__ Poor__

Do you like your smile? Yes___ No___ Do your gums ever bleed? Yes___ No___

Have you ever had an injury to your: Mouth Teeth Chin (Please Circle)

Do you grind your teeth or clench or jaw? Yes___ No___ If yes, please circle: While Awake? While Asleep?

Do you generally breathe through your mouth? Yes___ No___ If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth? Yes___ No___

What are the main issues that you would like orthodontic treatment to correct? (Improve alignment, crowding, spacing, overbite, bad bite, or suggested by dentist)____

____

Please provide any additional information / comments that you feel would enable us to provide the best experience for you during your visit with us. ____

____.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature____ Date__________________

THANK YOU FOR FILLING OUT FORM COMPLETELY