WELCOME TO OUR PRACTICE

WE WOULD LIKE TO WELCOME YOU AND YOUR CHILD TO OUR OFFICE. OUR GOAL IS TO MAKE EVEF VISIT PLEASANT AND EDUCATIONAL. WE STRIVE TO TEACH GOOD ORAL CARE THAT WILL ENABLE YOI HAVE A BEAUTIFUL SMILE THAT LASTS A LIFETIME.

JK ORTHODONTICS
JEFF B. KWONG DDS, MSD

Today's Date:___/____/_____

TELL US ABOUT YOUR CHILD

Date of Birth:____/____/_____

❑ Male ❑ Female

Child's Name: _____
LAST FIRST MI

Nickname: _____

School:_____Grade: _____

Hobbies:/Sports: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name:_____Relation: _____

Do You Have Legal Custody Of This Child? ❑ Yes ❑ No

Who May We Thank For Referring You?

List Brothers/Sisters With Age: _____

_____

General Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Separated

PARENT/GUARDIAN INFORMATION

❑ Mother ❑ Step Mother ❑ Guardian

Name:_____Birthdate: _____

Home address: _____

_____

CITY STATE ZIP

Email address: _____

Cell #: (____)_____Home #: (____) _____

Employer:_____Work #: (____) _____

❑ Father ❑ Step Father ❑ Guardian

Name:_____Birthdate: _____

Home address: _____

_____

CITY STATE ZIP

Email address: _____

Cell #: (____)_____Home #: (____) _____

Employer:_____Work #: (____) _____

PERSON RESPONSIBLE FOR ACCOUNT?

Name:_____Relation: _____

Billing Address (if different from home address): _____

_____

CITY STATE ZIP

Who is responsible for making appointments?_____

Name: _____

Work #: (____)_____Ext:_____Home #: (____) _____

Neighbor or Relative not living with you:

Name:_____Phone #: _____

Address: _____

_____

CITY STATE ZIP

ORTHODONTIC INSURANCE

Policy Owner's Birthdate:___/____/_____

Policy Owner's Employer: _____

Policy Owners SSN: _____

Dental Coverage? ❑ Yes ❑ No Ortho Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Employer: _____

SECONDARY INSURANCE

Dental Coverage? ❑ Yes ❑ No Ortho Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Policy Owners Birthdate:____/_____/_____

Policy Owners SSN: _____

Relationship to Patient: _____

Policy Owner's Employer: _____

Continued on back

827 Blossom Hill Rd. Ste W-4 San Jose, CA 95123 Ph: (408) 226-3000 Fax: (408) 226-9868

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

Has your child ever been evaluated or had orthodontic treatment before?
❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth, or chin? ❑ Yes ❑ No

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth?
❑ Yes ❑ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?
❑ Yes ❑ No

Does your child brush his/her teeth daily? ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: (____)_____ Date of Last Visit: _____

Is your child currently under the care of a physician? ❑ Yes ❑ No

Please describe your child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is currently taking:

_____

Please list all drugs/things that your child is allergic to?

_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

❑ Y ❑ N	Abnormal Bleeding	❑ Y ❑ N	Hearing Impairment
❑ Y ❑ N	ADD/ADHD	❑ Y ❑ N	Heart Murmur
❑ Y ❑ N	Allergic to any drugs	❑ Y ❑ N	Hemophilia
❑ Y ❑ N	Allergic to Latex/Metals	❑ Y ❑ N	Hepatitis
❑ Y ❑ N	Allergic to Plastic	❑ Y ❑ N	HIV+/AIDS
❑ Y ❑ N	Any Hospital Stays	❑ Y ❑ N	Kidney Problems Valves
❑ Y ❑ N	Any Operations	❑ Y ❑ N	Liver Problems
❑ Y ❑ N	Artificial Bones/Joints/	❑ Y ❑ N	Lupus
❑ Y ❑ N	Asthma	❑ Y ❑ N	Rheumatic/Scarlet Fever
❑ Y ❑ N	Cancer	❑ Y ❑ N	Sickle Cell Disease/Traits
❑ Y ❑ N	Congestive Heart Defect	❑ Y ❑ N	Tuberculosis (TB)
❑ Y ❑ N	Convulsions/Epilepsy		
❑ Y ❑ N	Diabetes		
❑ Y ❑ N	Handicaps/Disabilities		

Please discuss any medical problems that your child has had:

_____

_____

DOES/DID YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

❑ Y ❑ N	Clenching/Grinding Teeth	❑ Y ❑ N	Nursing Bottle
❑ Y ❑ N	Lip Sucking/Biting	❑ Y ❑ N	Speech Problems
❑ Y ❑ N	Thumb/Finger Sucking	❑ Y ❑ N	Mouth Breather
❑ Y ❑ N	Nail Biting	❑ Y ❑ N	Tongue Thrust

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY.

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office in any changes in my medical status. I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

_____

SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials:_____ Date: _____

Doctor's Comments: _____

_____

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