Noland D. Soo, DDS., MS.

Specialist in Orthodontics for Adults and Children

Patient Information

Name_____ _____ _____
Last First Middle Gender

Address_____ _____ _____ _____
Street City State Zip

Birth date_____ Social Security #_____ E-mail_____
MM/DD/YYYY 999-99-999

Home Phone_____ Cell Phone_____ School_____

General Dentist_____ Last Visited_____

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

Responsible Party Information

Name_____ _____ _____ _____
Last First Middle Gender

Address_____ _____ _____ _____
Street City State Zip

Birth date_____ Social Security #_____ E-mail_____
MM/DD/YYYY 999-99-999

Home Phone_____ Cell Phone_____ Work Phone_____ ext.____

Employer_____ Occupation_____

Relationship to Patient_____

Insurance Company_____ Group #_____

Insurance Co. Address_____ Insurance Phone #_____

Insured's Name_____ Insured's SS or ID #_____

Spouse/Other Responsible Party Information

Name_____ _____ _____ _____
Last First Middle Gender

Address_____ _____ _____ _____
Street City State Zip

Birth date_____ Social Security #_____ E-mail_____
MM/DD/YYYY 999-99-999

Home Phone_____ Cell Phone_____ Work Phone_____ ext.____

Employer_____ Occupation_____

Relationship to Patient_____

Insurance Company_____ Group #_____

Insurance Co. Address_____ Insurance Phone #_____

Insured's Name_____ Insured's SS or ID #_____

Medical History

Are you under the care of a physician? [ ] yes [ ] no If Yes, explain_____

Physician_____ Phone_____ Last Visit_____

Address_____

Are you taking any medications? [ ] yes [ ] no If so please list_____

_____

Are you allergic to: [ ] penicillin [ ] codeine [ ] local anesthetic [ ] latex

If any other allergies exist, please list _____

Have you had any trouble with the following? (Please check the appropriate box.)

	yes	no		yes	no
Heart trouble	[ ]	[ ]	Blood transfusions	[ ]	[ ]
Congenital heart problems	[ ]	[ ]	Hepatitis A, B, or C	[ ]	[ ]
Heart murmur	[ ]	[ ]	Psychiatric or mental problem	[ ]	[ ]
Stroke	[ ]	[ ]	Abnormal bleeding	[ ]	[ ]
Epilepsy/seizures	[ ]	[ ]	Scarlet fever	[ ]	[ ]
Venereal disease	[ ]	[ ]	Tuberculosis	[ ]	[ ]
High blood pressure	[ ]	[ ]	HIV	[ ]	[ ]
Rheumatic fever	[ ]	[ ]	AIDS	[ ]	[ ]
Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]
Anemia	[ ]	[ ]	Females: are you pregnant	[ ]	[ ]
Allergic to Phen Phen?	[ ]	[ ]	If yes, how many months?_____		

Have you ever been hospitalized or had a serious illness? If yes, please explain_____

_____

Do you have any condition or problem not mentioned above?_____

Dental History

Have you seen an orthodontist? If so, who? _____

What would you like to change about your teeth? _____

When was your last general dental examination? _____

Are you aware that some appointments may need to be scheduled during school hours? [ ] yes [ ] no

Do you or have you ever experienced the following?

	yes	no		yes	no
Sensitive teeth	[ ]	[ ]	Headaches	[ ]	[ ]
Teeth clenching or grinding	[ ]	[ ]	Speech problems	[ ]	[ ]
Bleeding gums	[ ]	[ ]	Bad dental experience	[ ]	[ ]
Unpleasant odor	[ ]	[ ]	Thumb or finger sucking	[ ]	[ ]
Injuries to jaws, or teeth	[ ]	[ ]	Sore teeth or jaws	[ ]	[ ]
Jaw popping or clicking	[ ]	[ ]	Locking of jaws	[ ]	[ ]

Signature

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences, and that it is my responsibility to inform this office of any changes in my personal information or medical or dental status. I also authorize the release of any information related to insurance claims and authorize payment of any insurance benefits to this office. I consent to the examination by Dr. Noland Soo and authorize the office to obtain necessary information from my dentist or physician related to my orthodontic care.

Patient/Parent/Guardian_____ Date_____