Tri-Valley Orthodontics
Jesse H. Ko DMD
Anne J. Yoon DDS MS

NEW PATIENT ORTHODONTIC ACQUAINTANCE FORM - ADULT

Date:_____/_____/_____ **How did you hear about us?:**_____
Reason for Consultation (Primary Concerns):_____

PATIENT INFORMATION

Patient's Full Name (Last): _____(First):_____
Date of Birth: Month:_____ Day_____ Year_____ Social Security #: _____-_____-_____
Email Address:_____ **Phone:** (____)_____-_____ Alt Phone:(____)_____-_____
Home Address: _____ Apt: ____City: _____ State_____Zip_____
Occupation:_____**Employer:**_____
Business Phone:(_____)_____-_____ Business Address:_____

DENTAL & MEDICAL CONTACT INFORMATION

General Dentist Name: _____Practice Name: _____
Phone:(_____) _____-_____ City: _____

Physician:_____ Practice (Hospital) Name: _____
Phone:(_____)_____-_____ City: _____

SPOUSE'S INFORMATION (if applicable):
*Name:*_____Email Address:_____
Phone: (_____)_____-_____ Occupation:_____Employer:_____

PERSON ASSUMING FINANCIAL RESPONSIBILITY (if different from above)
Name:_____ *Relationship to Patient:*_____ *Phone:(_____)_____-_____*
*Email Address:*_____*Home Address:*_____

INSURANCE INFORMATION

Primary Insurance Information
Policy Holder Name:_____Policy Holder Date of Birth: _____
Employer Name:_____Insurance Company Name:_____
Insurance Phone #:*(_____)*_____-_____Group Number:_____Subscriber ID:_____

Secondary Insurance (if applicable):*only your primary insurance benefits will be reflected on your contract; if desired we can prepare the paperwork for you to submit claims to your secondary insurance for you to collect directly from your secondary ins.*
Policy Holder Name:_____Policy Holder Date of Birth: _____
Employer Name: _____Insurance Company Name:_____
Insurance Phone #:*(_____)*_____-_____Group Number:_____Subscriber ID:_____

ADULT MEDICAL HISTORY Please answer Y (yes) or N (no)

Y/N Are you in good health?
Y/N Do you have any history of major illness? Please explain:
Y/N Have you ever been under the care of a physician for illness?
Y/N Have you ever been hospitalized? Please explain:
Date of last examination by physician:_____
Y/N Do you bruise easily
Y/N Have you ever required a blood transfusion?
Y/N Do you have a tendency to colds?
Y/N Do you have a tendency to sore throats?
Y/N Have you had your tonsils removed
If yes at what age?_____
Y/N Do you have chronic ear pain or infections?
Y/N Do you take sedatives, tranquilizers, sleeping pills or medicine to relax?
Y/N Do you have trouble sleeping?
List any drugs or medications you are currently taking:_____
Y/N If you are female are you pregnant?
Y/N Are you taking birth control pills?

Please indicate Y (yes) or N (no) to any condition below you have experienced:

Y/N	Heart murmur	Y/N	Tumors or growths
Y/N	Rheumatic Fever	Y/N	Thyroid/parathyroid problems
Y/N	High blood pressure	Y/N	Bone disorders
Y/N	Low blood pressure	Y/N	Seizures
Y/N	Hepatitis	Y/N	Endocrine problems
Y/N	Diabetes	Y/N	Frequent headaches
Y/N	Kidney disease	Y/N	Immune system problems
Y/N	Epilepsy	Y/N	Psychiatric care
Y/N	Fainting	Y/N	Prolonged bleeding
Y/N	Arthritis	Y/N	Anemia/blood pressure
Y/N	Asthma	Y/N	Tuberculosis
Y/N	Pneumonia	Y/N	Often fatigued/exhausted
Y/N	Nervous or anxious	Y/N	Recent weight gain/loss
Y/N	Cancer treatment	Y/N	Sinus trouble

Are you allergic or have reacted adversely to:

Y/N	Local anesthetics	Y/N	Aspirin
Y/N	Penicillin/other antibiotics	Y/N	Iodine
Y/N	Sulfa drugs	Y/N	Codeine or other narcotics
Y/N	Barbiturates, sedatives or sleeping pills	Other:_____	

DENTAL HISTORY (Date of your last dental examination or treatment_____)

Y/N Have you had any serious problems associated with prev. dental tx? Please explain:_____
Y/N Have there been any injuries to your face, mouth, or teeth? Please explain:_____
Y/N Have you had any tx for problems of your jaw joint or for facial muscle spasms? Please explain:_____

Y/N	Have you ever sucked your thumb or fingers?	Y/N	Clicking, popping or grating from your jaw?
	Until what age?_____	Y/N	Is there numbness/tingling w/ your face/mouth?
Y/N	Do you have any speech problems?	Y/N	Have you ever had orthodontics for a bad bite?
Y/N	Are you a mouth breather? At what times?_____	Y/N	Has an orthodontist been consulted previously?
Y/N	Have you been informed of any missing or extra teeth?	Y/N	Have you ever had periodontal (gum) disease?
Y/N	Do you wear a mouthguard or a splint?	Y/N	Has either parent had orthodontics treatment?
Y/N	Do you clench or grind your teeth?	Y/N	Has either parent had periodontal disease?

Print Full Name:_____

Signature:_____ Date:_____
By signing above you attest that the above is correct & is only intended for use in the office of Dr. Jesse Ko & Dr. Anne Yoon