DR. BUI AND TEAM WELCOME YOU TO OUR OFFICE!

18121 Magnolia Street, Fountain Valley, CA 92708
www.theorthobee.com ● (714) 962-8880

PATIENT INFORMATION

PREFERRED METHOD OF CONTACT:

LAST NAME	FIRST NAME	BIRTH DATE	S.S.N.	[ ] MALE [ ] FEMALE
MAILING ADDRESS STREET	CITY	ZIP	HOME PHONE	
SCHOOL (if student)	GRADE	[ ] SINGLE [ ] MARRIED [ ] SEPARATED [ ] DIVORCED [ ] WIDOW(ER)	EMPLOYER/OCCUPATION	CELL PHONE * / CELL CARRIER
E-MAIL (Required)	FAX		WORK PHONE	
NAME OF DENTIST	DATE OF LAST VISIT	WHOM MAY WE THANK FOR RECOMMENDING US?		

NAMES & AGES OF OTHER SIBLINGS/CHILDREN	
1	2
3	4

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE	
1	2

RESPONSIBLE PARTY INFORMATION (please complete if patient is a minor)

NAME ______	NAME ______
BIRTH DATE______ MARITAL STATUS______	BIRTH DATE______ MARITAL STATUS______
HOME PHONE______WORK PHONE______	HOME PHONE______WORK PHONE______
CELL PHONE______ FAX______	CELL PHONE______ FAX______
SSN______ E-MAIL______	SSN______ E-MAIL______
EMPLOYER______	EMPLOYER______
OCCUPATION______ NO. OF YEARS EMPLOYED______	OCCUPATION______ NO. OF YEARS EMPLOYED______

MAILING ADDRESS (if different from patient's)______

HOW MANY YEARS AT THIS ADDRESS?______ PREVIOUS ADDRESS (IF LESS THAN 3 YRS)______

INSURANCE INFORMATION

POLICYHOLDER'S NAME	RELATIONSHIP TO PATIENT	EMPLOYER/OCCUPATION	S.S.N.	BIRTH DATE
INSURANCE COMPANY	INSURANCE CO. PHONE	MEMBER ID		GROUP NO.
INSURANCE CO. ADDRESS	CITY	STATE		ZIP

GRAY AREA FOR OFFICE USE ONLY	EFFECTIVE DATE	WAITING PERIOD	AGE LIMIT	LIFETIME MAX.	%	USED
DEDUCTIBLE	INITIAL PAYMENT	SUBMIT [ ]ONCE [ ] MONTHLY [ ] QUARTERLY	INSURANCE PAYS [ ] MONTHLY [ ] QUARTERLY	ADDITIONAL INFO		

I understand that I am financially responsible for all charges for services to me/my dependent, including the balance remaining after payment of possible insurance benefits. I hereby authorize and direct payment of the dental benefits otherwise payable to me directly to Dr. Bui's office. I consent to your use and disclosure of my/my dependent's protected health information for insurance claims.
**By providing my cell phone number, I am consenting to be contacted by Dr.Bui's office on matters related to treatment, financial account, insurance and practice promotions.*

Signature (Patient/Responsible Party)______ Date______

MEDICAL HISTORY

Please check Y or N

[Y] [N]		[Y] [N]	
[ ] [ ]	Abnormal Bleeding	[ ] [ ]	High/Low Blood Pressure
[ ] [ ]	ADD/ADHD	[ ] [ ]	Kidney Problems
[ ] [ ]	Anemia	[ ] [ ]	Liver Problems
[ ] [ ]	Arthritis	[ ] [ ]	Pregnancy Now
[ ] [ ]	Artificial Bones/Valves	[ ] [ ]	Psychiatric Problems
[ ] [ ]	Asthma	[ ] [ ]	Sleep Apnea
[ ] [ ]	Cancer	[ ] [ ]	Sinus Problems
[ ] [ ]	Diabetes	[ ] [ ]	Stroke
[ ] [ ]	Difficulty Breathing	[ ] [ ]	Substance Abuse
[ ] [ ]	Dizziness or Fainting	[ ] [ ]	Tobacco Use
[ ] [ ]	Epilepsy or Seizures	[ ] [ ]	Thyroid Problems
[ ] [ ]	Hepatitis	[ ] [ ]	Tuberculosis
[ ] [ ]	HIV/AIDS	[ ] [ ]	Venereal Diseases

OTHER____

DENTAL HISTORY

Please check if patient has or has had

[Y] [N]	
[ ] [ ]	Any Previous Orthodontic Consultations
[ ] [ ]	Clenching/Grinding
[ ] [ ]	Difficulty Swallowing/Chewing
[ ] [ ]	Mouth Breathing
[ ] [ ]	Speech Problems
[ ] [ ]	Tongue Thrust
[ ] [ ]	Thumb/Finger/Lip Sucking
[ ] [ ]	TMJ Problems
[ ] [ ]	Injuries to Face or Mouth
[ ] [ ]	Missing/Extra Teeth

OTHER_________________________

PATIENT'S PHYSICIAN____ LAST PHYSICAL EXAM______________

Is the patient allergic to latex, nickel, penicillin, etc.? **[YES] [NO]** LIST ALLERGIES:	Is the patient taking/has the patient taken Bisphophosphonates? **[YES] [NO]** Does the patient need to be pre-medicated for dental treatment? **[YES] [NO]** REASON:
Is the patient using any medications at this time? **[YES] [NO]** LIST MEDICATIONS:	Has the patient ever been hospitalized? **[YES] [NO]** REASON: Is the patient under the care of a physician at this time? **[YES] [NO]** REASON:

EMERGENCY CONTACT INFORMATION (nearest relative not living with patient)

NAME____ RELATIONSHIP____________________

ADDRESS (Street, City, State, Zip)____

HOME PHONE_____________________ CELL PHONE_______________________ WORK PHONE_____________________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental services that may be needed.

Signature (Patient or Responsible Party)________________________________ **Date**____________________________

MEDICAL HISTORY UPDATE (please DO NOT fill out on first visit)

Have there been any changes in the patient's health status since his/her first visit? **[YES] [NO]**

If yes, please explain____

Signature (Patient or Responsible Party)____ **Date**_______________________

Signature (Orthodontist) ____ **Date**_______________________