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 **DENTAL 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_____

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_____