



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 [] SEPARATED [] WIDOW(ER)	[] MARRIED [] DIVORCED	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]

Abnormal Bleeding
 ADD/ADHD
 Anemia
 Arthritis
 Artificial Bones/Valves
 Asthma
 Cancer
 Diabetes
 Difficulty Breathing
 Dizziness or Fainting
 Epilepsy or Seizures
 Hepatitis
 HIV/AIDS

[Y] [N]

High/Low Blood Pressure
 Kidney Problems
 Liver Problems
 Pregnancy Now
 Psychiatric Problems
 Sleep Apnea
 Sinus Problems
 Stroke
 Substance Abuse
 Tobacco Use
 Thyroid Problems
 Tuberculosis
 Venereal Diseases

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 _____

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 Bisphosphonates? [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 _____