LAUREN CAI DDS, MS
FAMILY ORTHODONTICS

PATIENT INFORMATION

Today's Date: ______ Birthdate: ______ Age: ______ Male / Female

PATIENT'S NAME: ______
Last First Middle

Address: ______
Street City Zip

Phone #: ______ Cell / Home / Work

Prefers to be called: ______ Who is with the patient today? ______

Who may we thank for referring you to our office? ______

School: ______ Grade: ______

List other family members seen by us: ______ Parent marital status: Single / Married / Divorced

RESPONSIBLE PARTY INFORMATION

Name: ______
Last First Middle

Address: ______
Street City Zip

How Long at this address? ______

Daytime #: ______ Cell / Home / Work

Evening #: ______ Cell / Home / Work

Email Address: ______

Birthdate: ______

Relationship to Patient: ______

Employer: ______

Occupation: ______

Years Employed: ______

RESPONSIBLE SPOUSE INFORMATION

Name: ______
Last First Middle

Address: ______
Street City Zip

How Long at this address? ______

Daytime #: ______ Cell / Home / Work

Evening #: ______ Cell / Home / Work

Email Address: ______

Birthdate: ______

Relationship to Patient: ______

Employer: ______

Occupation: ______

Years Employed: ______

PRIMARY ORTHODONTIC-DENTAL INSURANCE

Policy Holder's Name: ______

Insurance Company: ______

Insurance Billing Address: ______

______

Group #: ______ Insurance ID or SSN: ______

Relationship to Patient: ______

Insured Birthdate: ______

Insured Employer: ______

Insurance Co Phone #: ______

Orthodontic Coverage Yes / No How Much? $ ______

SECONDARY ORTHODONTIC-DENTAL INSURANCE

Policy Holder's Name: ______

Insurance Company: ______

Insurance Billing Address: ______

______

Group #: ______ Insurance ID or SSN: ______

Relationship to Patient: ______

Insured Birthdate: ______

Insured Employer: ______

Insurance Co Phone #: ______

Orthodontic Coverage Yes / No How Much? $ ______

I authorize the release of information to my insurance company and Lauren Cai, DDS, MS to bill and receive direct payment for services.

Signed ______

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Vancouver, WA 98684
(360) 882-5090

DENTAL INFORMATION

Patient Name: ______________________ **Age:** __________ **Today's Date:** __________

Dentist Name: ______________________

What would you like to change about your smile? ______________________

____

Would you like to wear braces ☐ or Invisalign ☐

yes no Do you floss? Times per day? __________

yes no Do you brush your teeth? Times per day? __________

Circle all that apply: No Pain

Bleeding gums Bad Taste Mouth Odor

Difficulty chewing Jaw Clenching Clicking Locking

Tooth grinding Clenching

Injuries To Face Mouth Teeth Chin

Last Visit? ______________________

Have you had previous Orthodontic work or a consultation done?

yes / no If so, where? ______________________

Circle:

yes no Do you gag easily?

yes no Are your teeth sensitive?

yes no Have you had problems with previous dental treatments?

yes no Are you apprehensive about dental treatment?

yes no Do you play a musical instrument?

What Type? ______________________

yes no Do you play a sport?

MEDICAL INFORMATION

<u>NOW OR IN THE PAST, HAS PATIENT HAD:</u>

yes no Allergies to medications? Ibuprofen, Acetaminophen?

Other? ______________________

yes no Allergies to latex, metal, other: ______________________

yes no Prosthetic joint or other replacement? When? __________

Which Joint? ______________________

yes no Has a physician recommended that patient take antibiotics prior to his/her dental treatment?

yes no Use tobacco (chew, smoke, vape, snuff)? packs/day? ____

yes no Taking any prescription or non-prescription medication, nutritional supplements, or herbal medicines?

Medication: __________ Taken For: __________

Medication: __________ Taken For: __________

Medication: __________ Taken For: __________

yes no History of Major Illness? ______________________

____

yes no Operations or Accidents?

When? ______________________

yes no Osteoporosis? Bone density issues? Taking medications for bone density or may have to in the future?

What Drug? __________ Started? __________

Circle all that apply:

Arthritis	Anemia	Asthma/Hay fever
Bone Disorders	Diabetes	Dizziness/Fainting
Aids/HIV Positive	Hepatitis	Herpes
Nervous Disorders	Pneumonia	Bleeding
High Blood Pressure	Kidney Disorder	Liver Disorder
Rheumatic Fever	Tuberculosis	Tumor/Cancer
Heart Problems	Heart Murmur	Epilepsy
Gastrointestinal	ADHD	Psychological Disorder

yes no Any other conditions you feel we should know about?

____

WOMEN ONLY

yes no Has menstruation begun? When? __________

yes no Pregnant now?

I have completed this form to the best of my knowledge and it is my responsibility to inform the office of any changes.

EMERGENCY INFORMATION

Name of nearest relative/friend not living with you:

____

Last *First* *Middle*

Relationship to Patient: ______________________

Phone: (____) ______________________

Signature: ______________________ **Date:** __________

Guardian/Responsible Party/Patient

Reviewed by: ______________________ **Date:** __________

Office Staff