Welcome

Roger S. Lim, DDS, MS, Inc.
13320 Riverside Dr. #218, Sherman Oaks, CA 91423, 818-783-4565
orthoarts@sbcglobal.net / www.orthoartscenter.com

Please take a few minutes to fill out the questionnaire so we can best serve your needs.
Thank you for your attention as we desire to know you better.

Patient's Name_____Nickname _____
Last First Middle Initial
Date of Birth _____ Age_____ Gender_____
Social Security Number or Insurance Card ID #_____
Address _____City _____State _____ Zip_____
Home Phone( )_____ Cell Phone ( )_____
Patient's email_____ Work Phone ( )_____
School or Employer Firm Name_____School Grade, Major, or Occupation_____
Patient's Favorite Sports or Hobbies_____
How did you hear about us? From Dr._____ From my relative/friend_____
From my insurance company_____ Other_____
Do you prefer appointment reminders by email, text message, or both? (Please circle).
For the next question: write 1 for the most important, 2 for 2nd most, and 3 for 3rd most.
Do you prefer 1)___a paid in full discount, 2)___low monthly payments, or 3)___a low down payment?

If patient is a minor (under age 18) or a fulltime student, then complete parent's information below:
I am the patient's (circle one)… Mother Father Legal Guardian
Mother's (or Legal Guardian's) Name _____
Work Phone( )_____ Cell Phone ( )_____
Mother's (or Legal Guardian's) email _____
Employer Firm Name_____ Occupation and Title_____
Father's (or 2nd Legal Guardian's) Name _____
Work Phone( )_____ Cell Phone ( )_____
Father's email _____
Employer Firm Name_____ Occupation and Title_____
Patient resembles (circle one) Mother Father Is adopted
Names and ages of siblings _____
Patient's Parents are (circle one) Married Widowed Separated Divorced Single

Primary Orthodontic Insurance (if any)	**Secondary Orthodontic Insurance (if any)**
Insurance Company Name_____	Insurance Company Name_____
Insurance Phone_____	Insurance Phone_____
Subscriber's Name _____	Subscriber's Name_____
Relationship to Patient_____	Relationship to Patient_____
Date of birth _____	Date of birth _____
SS Number or Insurance ID#_____	SS Number or Insurance ID#_____

In case of emergency, contact _____ Phone ( )_____
If deemed necessary, I authorize the taking of study models, x-rays, photographs, or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's orthodontic needs. X-rays may be at no charge if used for in-office review, but if you request a copy, email, or forwarding of the x-rays, then a $50 fee will apply per x-ray. If there are any changes in the information on these forms, I understand that it is my responsibility to update this office.

_____ _____
Signature Date

Medical History

Physician's or Medical Office Name _____ Date of Last Visit _____

Have you been a patient in a hospital? Yes / No
If yes, describe _____
Are you currently under medical care? Yes / No
If yes, describe _____
Are you taking any medications now? Yes / No
If yes, describe_____
Have you ever had a serious illness or operation? Yes / No
If yes, describe _____
Have you ever taken Phen-Fen or Redux? Yes / No
Do you smoke? Yes / No
Are you allergic to any medicine? Yes / No
If yes, describe _____
Are you pregnant or think you may be? Yes / No
Are you taking oral contraceptives? Yes / No

Do you have any of the following conditions?

Heart Trouble	Yes / No	Kidney Problems	Yes / No	Seizures/Fainting Spells	Yes / No
Heart Attack	Yes / No	Hepatitis	Yes / No	Epilepsy	Yes / No
Coronary Insufficiency	Yes / No	Jaundice	Yes / No	Cerebral Palsy	Yes / No
Coronary Occlusion	Yes / No	Liver Disease	Yes / No	Psychiatric Treatment	Yes / No
High Blood Pressure	Yes / No	Excessive Bleeding	Yes / No	Venereal Disease	Yes / No
Arteriosclerosis	Yes / No	Tuberculosis	Yes / No	AIDS/HIV	Yes / No
Stroke	Yes / No	Lung Problems	Yes / No	Hives/Rashes	Yes / No
Mitral Valve Prolapse	Yes / No	Persistent Cough	Yes / No	Thyroid Disease	Yes / No
Heart Murmur	Yes / No	Emphysema	Yes / No	Nervous Disorder	Yes / No
Rheumatic Fever/	Yes / No	Sinus Problems	Yes / No	ADD/ADHD	Yes / No
Rheumatic Heart Disease	Yes / No	Stomach Ulcers	Yes / No	Mental Disability	Yes / No
Sickle Cell Disease	Yes / No	Diabetes	Yes / No	Hearing Disability	Yes / No
Bleeding Disorder	Yes / No	Inflammatory Rheumatism	Yes / No	Developmental Disability	Yes / No
Anemia	Yes / No	Arthritis	Yes / No	Cleft Lip/Palate	Yes / No
Congenital Heart Disease	Yes / No			Premature Birth	Yes / No
PenicillinAmoxicillinAllergy	Yes / No			How many weeks? _____	
Allergic to _____	Yes / No				

Do you have any conditions not mentioned above? If yes, what:_____

Dental History

Reason for Today's Visit and What concerns do you have about your teeth?_____
When was your most recent visit to the general dentist?_____
General Dentist _____ Phone _____
Address _____
Have there been any injuries to the face, mouth or teeth? Yes / No
If yes, describe: _____
Have you ever sucked a thumb or fingers? Yes / No
If yes, until what age? _____
Do you have any speech problems? Yes / No
If yes, describe: _____
Are you a mouth breather while awake or asleep? Yes / No
Do you bite your nails, lip or tongue? Yes / No
Do you grind your teeth at night? Yes / No
Has either parent had orthodontic treatment? Yes / No
Have you been informed of any missing or extra permanent teeth? Yes / No
Has an orthodontist been consulted previously? Yes / No
If yes, who and when? _____
Have we treated any other family members? Yes / No
If yes, who? _____
I have answered all questions truthfully and to the best of my knowledge.

_____	_____	_____
Name of patient (please print)	Signature	Date
_____	_____	_____
Name of parent/legal guardian (please print)	Signature	Date
_____	_____	_____
Review Medical History/Comments	Dentist Signature	Date

For recall patients only: Medical History Update
I have reviewed the above medical history and there have been no changes since the first date I signed above.

_____	_____	_____	_____
Signature	*Date*	*Signature of Dentist*	*Date*

For recall patients only: Medical History Update
I have reviewed the above medical history and there have been no changes since the first date I signed above.

_____	_____	_____	_____
Signature	*Date*	*Signature of Dentist*	*Date*