Teresa S. Lee DDS

Welcome to our office !

Today's date: _____

Please take a few minutes to provide us with the following important information.

Name: _____
Birth date: _____/_____/_____
Social Security #: _____
Home address: _____
_____
City: _____ Zip Code: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
E-mail: _____
Occupation: _____
Employer: _____

Dentist: _____
Dentist's Address: _____

Dental Insurance Information
Primary Insurance: _____
Subscriber's name: _____
Group number: _____
Member ID: _____
Relationship to p atient: _____ _____

Secondary Insurance: _____
Subscriber's name: _____
Group number: _____
Member ID: _____
Relationship to patient: _____

Other adults we should know about? YES / NO
Name: _____
Relationship to you? _____ _____
Phone (H) _____ (W) _____

How did you find us? Check all the items relevant you.

- ☐ Referred by a dentist: Dr._____
- ☐ Dental Insurance/ website
- ☐ Referred by family/friend :_____
- ☐ Referred by one of Dr. Lee's patient: _____
- ☐ Family member was treated/is being treated by Dr. Lee
- ☐ Through church, community, etc.
- ☐ Saw Dr. Mattia's office in the area
- ☐ Magazine/Newspaper
- ☐ Dr. Mattia's website
- ☐ Invisalign web site / customer service
- ☐ Dr. Mattia's team member
- ☐ Other _____

Medical Information: Do you have (or have you had) any of the following?

- ☐ Aliergies/sensitivities to medicine, metal, latex _____
- ☐ Tonsillitis (or date removed) _____
- ☐ Liver problems/hepatitis
- ☐ Heart problems
- ☐ HIV/AIDS
- ☐ Smoke cigarettes? (_____/day)
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Cancer
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Epilepsy
- ☐ Eye problems
- ☐ Stomach problems
- ☐ Bleeding disorders/transfusion/anemia
- ☐ Rheumatic fever
- ☐ Emotional/nervous/psychiatric issues
- ☐ Fainting or dizziness
- ☐ Headaches
- ☐ Heart Murmur
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Respiratory disease
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Ear aches
- ☐ Asthma: use inhaler _____x/week
- ☐ Kidney problems
- ☐ Thyroid disorder
- ☐ Bone disorder
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Low blood pressure
- ☐ Chemical Dependency
- ☐ Back problems
- ☐ Glaucoma
- ☐ Jaw pain

Describe any other medical issues (medication, illness, surgery) if not listed above.

_____

Physician's name, address, and phone number: _____

Last physical exam date: _____

Continued.....

HOW CAN WE HELP YOU?

To satisfy your concerns, we need to know more about your reason for visiting our office today. Please answer the following questions to the best of your knowledge.

1. Are you satisfied with the way your teeth look? [YES, NO]

If you circled NO, tell us, how would you change them? (Try to be specific, for example, "lower teeth are crooked," "don't like the upper gap"): _____

2. Do you have any concerns about the bite or the way the teeth fit together? [YES, NO]

If YES, please try to tell us what the problem is: _____

_____

3. Do you have any concerns about the facial appearance/profile? [YES, NO]

If YES, please tell us if you know what you would like to see changed. (Try to be specific, for example, "I'd like to show less gum when smiling.")_____

4. Are you here mainly on the advice of your dentist? [YES, NO]

5. Anything else you would like to discuss? _____

Dental Background

When was your last check-up/cleaning with the dentist? _____

Are there any on-going dental problems which have not been treated yet? (for example: cavities, root canal) [YES / NO]

_____

How often do you brush? _____times / day Floss? _____times / week

Have you ...

had previous orthodontic treatment or consultation? If YES, when was it? _____	YES ○	NO ○
seen a gum specialist, root canal dentist, or oral surgeon?	YES ○	NO ○
had any root canals, large fillings, crowns, bridges, dental implants before? (Circle one).	YES ○	NO ○
had trouble associated with dental treatment?	YES ○	NO ○
been told that you have any gum disease or periodontal disease?	YES ○	NO ○
ever injured or broken any teeth? If YES, when and what happened? _____	YES ○	NO ○
ever injured the head or face? If YES, when and what happened? _____	YES ○	NO ○
had any teeth extracted? If YES, what was the reason? _____	YES ○	NO ○

Do you ...

have any problems with eating, chewing, or swallowing?	YES ○	NO ○
have any dental/facial pain or headaches? If YES, how frequently? (_____ times /day, week, month)	YES ○	NO ○
have a jaw joint that makes noises/hurts when opening/closing/chewing?	YES ○	NO ○
grind or clench the teeth together? If YES, during daytime/sleeping? (Circle one) Sleeping	YES ○	NO ○
have problems breathing through the nose?	YES ○	NO ○
have any speech difficulties?	YES ○	NO ○
have any swellings or growths in the face or mouth?	YES ○	NO ○
have any negative or resistant feelings about orthodontic treatment? (for example, refuse to get braces, only want Invisalign)	YES ○	NO ○
have any missing or extra teeth?	YES ○	NO ○
Has any member of the family had any orthodontic treatment?	YES ○	NO ○
Any other information that Dr. Lee should be aware of? _____		

Thank you for your patience in filling out this information. Your effort will assist us in treating you to the best of our ability.

Patient signature _____ Date _____