SAN RAMON
CHILDREN'S DENTISTRY
AND ORTHODONTICS

JEFFREY LEONG, DDS, MS

Date: _____

Patient Information

Patient's Full Name_____ Age _____ Sex (M) (F)

Nickname (if any) _____Birthdate _____ SSN _____

Whom may we thank for referring you _____

Home Address _____ Home Phone _____

Employer_____ Cell Phone _____

Business Address _____ Work Phone _____

E-mail Address _____

Responsible Party If Applicable

Father (full name) _____SSN _____ Birthdate _____

Mother (full name) _____SSN _____Birthdate _____

Parent(s) are: Married Divorced Single Widowed Partners Child lives with: _____

Home Address _____Zip Code_____ Home Phone _____

Father's Employer_____ Cell Phone _____

Business Address _____ Work Phone _____

Mother's Employer _____Cell Phone _____

Business Address _____ Work Phone _____

E-mail Address _____ Person Financially responsible _____

Emergency Contact _____ Phone _____

How would you like us to contact you? Home Work Cell E-mail

SIGNATURE _____ Relationship _____

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Patient's Name: _____

Health History

Patient's Physician: _____Telephone #_____

Have you had any unfavorable reactions to drugs, antibiotics or anesthetics? (Y) (N)

If yes, please list _____

Are you currently taking any medications? (Y) (N) What kind? _____

ADHD/ADD	(Y)	(N)	Bone Disorder	(Y)	(N)
Delayed Development	(Y)	(N)	Cancer/Malignancy	(Y)	(N)
Down's Syndrome	(Y)	(N)	Chemo/Radiation Therapy	(Y)	(N)
Autism	(Y)	(N)	Cystic Fibrosis	(Y)	(N)
Asthma/lung problems	(Y)	(N)	Allergies to Meds	(Y)	(N)
Tuberculosis	(Y)	(N)	Diabetes	(Y)	(N)
Anemia	(Y)	(N)	Arthritis/Joint problems	(Y)	(N)
Bleeding Disorder	(Y)	(N)	Cardiac Disease/Heart	(Y)	(N)
Bruising	(Y)	(N)	Epilepsy/Seizure	(Y)	(N)
Hepatitis	(Y)	(N)	Bladder problems	(Y)	(N)
Brain Injury	(Y)	(N)	Cerebral Palsy	(Y)	(N)
Earaches/Infections	(Y)	(N)	Emotional/School Problems	(Y)	(N)
Hearing Impaired	(Y)	(N)	Depression/Anxiety	(Y)	(N)
Rheumatic Fever	(Y)	(N)	Eating Disorder	(Y)	(N)

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN: _____

_____

_____

Dental History

Name of your dentist? _____Phone _____

Date of last visit _____ Were X-rays taken? (Y) (N)

Have you had any injuries to teeth, mouth or head? (Y)(N) Please describe: _____

Do you have any of the following habits? (past or present)? Please circle: Thumb/finger-sucking Nail-biting Lip-sucking Mouth-breathing Teeth-Grinding Snoring

How often do you brush your teeth per day? _____ How often do you floss? _____

What is the main reason for visiting the orthodontist today?_____

I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my health status. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage.

Patient Signature: _____ Date_____

Parent/GuardianSignature: _____ Date_____

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Name: _____

Insurance Information

Primary Insurance Company _____Phone Number _____

Subscriber _____ Birthdate _____ Group Number _____

Secondary Insurance Company _____Phone Number _____

Subscriber _____ Birthdate _____Group Number _____

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for treatments your child receives. However, in the event the insurance company, for any reason, does not pay, the balance will become your responsibility, and will be billed directly to you. You understand that this contract is with San Ramon Children's Dentistry and Orthodontics and yourself, and you are responsible for all charges on the account.

SIGNATURE OF RESPONSIBLE PARTY _____

Relationship _____ Date _____