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 _______________________

SAN RAMON
CHILDREN'S DENTISTRY
AND ORTHODONTICS

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__________________

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 ______________________________