Lennard Orthodontics
Ian P. Lennard, DDS, MS

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San Jose, CA 95120

WELCOME TO LENNARD ORTHODONTICS!

Date_____

Patient's Name_____ SS#_____ Sex___ DOB_____ Age__
Address_____ City_____ State_____ Zip _____
Home # _____Cell # _____ Email _____
Work # (if applicable) _____ Employer (if applicable) _____
School_____ Grade ___ Interests/Sports/Hobbies _____

Father's (or husband's) Name_____ ID/SS# _____
Address (if different from above) _____DOB_____
Work #_____Cell #_____ Email _____
Employer_____ Occupation _____
Dental Insurance _____ Plan Name_____ Group #_____

Mother's (or wife's) Name _____ ID/SS# _____
Address (if different from above) _____ DOB _____
Work #_____Cell #_____ Email _____
Employer_____ Occupation_____
Dental Insurance_____ Plan Name_____ Group#_____

Siblings' Names and Ages _____
Dentist_____ Physician _____

How did you hear about us? _____
What brings you to our office today?_____

For Office Use

Chief Concern _____
Diagnosis _____
_____
_____
_____

Treatment _____
_____
_____

Est. Treatment Time_____ Phase I _____ Phase II _____
Fee Estimate_____ Phase I _____ Phase II _____

Date	Treatment	Next Appt.

DENTAL HISTORY

Please circle all that apply

Y N Does patient see a dentist regularly?
Date of last appointment_____
Y N Fluoride treatment in dental office?
Y N Fluoride drops or pills or fluoridated water?
Y N Has patient sucked thumb or fingers?
Until what age?_____

Y N Is patient a mouth breather?
Y N Does patient grind or clench teeth?
Y N Speech problems or speech therapy?
Y N Difficulty chewing or swallowing?

Y N Were any teeth removed by extraction?
Explain_____
Y N Has patient been informed of having missing or extra permanent teeth?

Y N Pain, clicking or popping when opening or closing mouth?
Y N Severe injuries to head or face?
Y N Head or neck pain?
Y N TMJ (jaw joint) problems?
Y N Orthodontic treatment in the past?
Y N Other orthodontic consultations?
Y N Have any family members had orthodontic treatment? If so, who? _____
Y N Is patient adopted? At what age? _____
Y N Are you aware that some appointments will infringe on school/work time?
Y N Have you had any periodontal/gum disease?
What concerns do you have about the appearance and/or function of your teeth?
_____

MEDICAL HISTORY

Are you currently under a physician's care?_____ Reason _____

Please rate patient's medical health:
GOOD FAIR POOR

Y N Is patient taking any meds?
If yes, please list_____
_____
Y N Is patient allergic to any meds?
If yes, please list_____
_____
Y N Does patient need to be pre-medicated before dental treatment? Explain _____
Y N Has patient had adenoids or tonsils removed?
Y N Other operations or hospitalizations?
If yes, please describe_____
_____
_____

Does the patient have or ever had any of the following conditions? If yes, please circle:

Heart Murmur	High Blood Pressure
Heart Problems	Growth Disorders
Latex Allergy	Cleft Lip/Palate
Snoring/Sleep Apnea	Diabetes
Fainting/dizziness	HIV+/AIDS
Epilepsy	Hepatitis
Hyperactivity/ADHD	Allergies
Arthritis	Asthma

Please describe any other medical conditions not mentioned above_____
_____
_____

Remarks_____
_____

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest of confidence. I also understand that I will be assisted with insurance claims to obtain maximum benefits, but that I am ultimately responsible for payment for all services rendered by Ian P. Lennard, DDS, MS. I shall inform my doctor and staff of any changes to my health status.

X_____ **Date**_____
Signature of patient, parent or guardian