DR. YUCI MA
SPECIALIST IN ORTHODONTICS
ORTHODONTIC ASSOCIATES OF LEXINGTON
(781) 860-7997
www.drmaorthodontics.com

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask - we will be happy to help.

New Patient Information *(CONFIDENTIAL)*

Date_____

Name _____ Sex _____ Birthdate _____ SS#_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Cell phone_____ Work phone_____

Email_____

Please Check Appropriate Box: ◯ *Minor* ◯ *Single* ◯ *Married* ◯ *Divorced* ◯ *Widowed* ◯ *Separated*

Whom May We Thank For Referring You To Us?_____

Emergency Contact_____ Relationship to Patient_____ Phone_____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient_____ Sex_____ Birthdate _____ SS#_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Cell phone_____

Employer_____ Work Phone_____

Is this Person Currently a Patient in our Office? *Yes* ◯ *No* ◯

Insurance Information

Name of Insured_____

Relationship to Patient_____ Sex_____ **Birthdate** _____ **SS#**_____

Name of Employer_____ Union/Local#_____ Work Phone_____

Insurance Company_____ **Group#**_____**PolicyID#**_____

-------IF YOU HAVE ADDITIONAL INSURANCE, PLEASE COMPLETE THE FOLLOWING-------

Name of Insured_____

Relationship to Patient_____ Sex_____ Birthdate _____ SS#_____

Name of Employer_____ Union/Local#_____ Work Phone_____

Insurance Company_____ Group#_____Policy ID #_____

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Patient Medical History

Name of Physician and Location_____ Date of Last Exam_____

1. Are you under medical treatment now? *Yes* ◯ *No* ◯
2. Have you ever been hospitalized for any surgeries or illnesses within the last 5 years? *Yes* ◯ *No* ◯

   If yes, please explain_____
3. Are you taking any medications? *Yes* ◯ *No* ◯ Including non-prescription medicine? *Yes* ◯ *No* ◯

   If yes, what medications?_____
4. Have you ever taken Fen-Phen/Redux? *Yes* ◯ *No* ◯
5. Do you use tobacco? *Yes* ◯ *No* ◯
6. Do you use controlled substances? *Yes* ◯ *No* ◯
7. Do you wear contact lenses? *Yes* ◯ *No* ◯
8. Do you have a persistent cough or throat-clearing not associated with a known illness? *Yes* ◯ *No* ◯
9. Do you have or have you had any of the following?

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
High Blood Pressure	◯	◯	Heart Disease	◯	◯	Chest Pains	◯	◯
Heart Attack	◯	◯	Cardiac Pacemaker	◯	◯	Easily Winded	◯	◯
Rheumatic Fever	◯	◯	Heart Murmur	◯	◯	Stroke	◯	◯
Swollen Ankles	◯	◯	Angina	◯	◯	Hay Fever/ Allergies	◯	◯
Fainting/Seizures	◯	◯	Frequently Tired	◯	◯	Tuberculosis	◯	◯
Asthma	◯	◯	Anemia	◯	◯	Radiation Therapy	◯	◯
Low Blood Pressure	◯	◯	Emphysema	◯	◯	Glaucoma	◯	◯
Epilepsy/ Convulsions	◯	◯	Cancer	◯	◯	Recent Weight Loss	◯	◯
Leukemia	◯	◯	Arthritis	◯	◯	Liver Disease	◯	◯
Diabetes	◯	◯	Joint Replacement or Implant	◯	◯	Heart Trouble	◯	◯
Kidney Disease	◯	◯	Hepatitis/ Jaundice	◯	◯	Respiratory Problems	◯	◯
AIDS or HIV Infection	◯	◯	Sexually Transmitted Disease	◯	◯	Mitral Valve Prolapse	◯	◯
Thyroid Problem	◯	◯	Stomach Troubles / Ulcers	◯	◯	Other_____		

10. Are you allergic to or have any reactions to the following?

Local Anesthetics (e.g. Novacain) *Yes* ◯ *No* ◯
Sulfa Drugs *Yes* ◯ *No* ◯
Sedatives *Yes* ◯ *No* ◯
Aspirin *Yes* ◯ *No* ◯
Latex Rubber *Yes* ◯ *No* ◯
Penicillin or any other Antibiotics. *Yes* ◯ *No* ◯
Barbiturates *Yes* ◯ *No* ◯
Iodine *Yes* ◯ *No* ◯
Any Metals (nickel, mercury, etc.) *Yes* ◯ *No* ◯
Other (please list)_____

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11. Women Only:
a) Are you or might you be pregnant? *Yes* ◯ *No* ◯ b) Are you nursing? *Yes* ◯ *No* ◯
c) Are you taking contraceptives? *Yes* ◯ *No* ◯

Patient Dental History

Name of Dentist and Location_____ Date of Last Exam_____

1. Are your teeth sensitive to hot or cold liquids/foods? *Yes* ◯ *No* ◯
2. Are your teeth sensitive to sweet or sour liquids/foods? *Yes* ◯ *No* ◯
3. Do you feel pain in your teeth? *Yes* ◯ *No* ◯
4. Do you have any sores or lumps in or near your mouth? *Yes* ◯ *No* ◯
5. Have you had any head, neck, or jaw injuries? *Yes* ◯ *No* ◯
6. Do your gums bleed when brushing or flossing? *Yes* ◯ *No* ◯
7. Have you ever experiences any of the following problems with your jaw?

   Clicking *Yes* ◯ *No* ◯ Pain (joint, ear, side of face) *Yes* ◯ *No* ◯

   Difficulty opening or closing *Yes* ◯ *No* ◯ Difficulty chewing *Yes* ◯ *No* ◯
8. Do you frequently get headaches? *Yes* ◯ *No* ◯
9. Do you clench or grind your teeth? *Yes* ◯ *No* ◯
10. Do you bite your lips or cheeks frequently? *Yes* ◯ *No* ◯
11. Have you ever had any difficult extractions in the past? *Yes* ◯ *No* ◯
12. Have you ever had prolonged bleeding after an extraction? *Yes* ◯ *No* ◯
13. Have you had any orthodontic treatment? *Yes* ◯ *No* ◯
14. Do you wear dentures or partials? *Yes* ◯ *No* ◯

    * if yes, date of placement_____
15. Have you ever received oral hygiene instruction regarding the care of your teeth and gums? *Yes* ◯ *No* ◯
16. Do you like your smile? *Yes* ◯ *No* ◯

Authorization and Release

I certify that I have read and that I understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the orthodontist to release any information including the diagnosis, and the records of any treatment or examination rendered to me during the period of such orthodontic care to third party providers and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*X*_____ *Date*_____

Signature of Patient (or parent/guardian if minor)