



Chesterfield Orthodontics
8092 Edwin Raynor Blvd., Suite C
Pasadena, MD 21122
410-255-0200
www.cforthodontics.com

Dr. Robert Yoon

Patient's Name _____ Preferred name: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender: _____ **General Dentist:** _____

Email for Appointment Reminders: _____ Phone number for reminders: _____

Whom may we thank for referring you to our office? _____

Other Family Members in Treatment: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____ Marital Status: _____

Home Address: _____

Social Security Number: _____ Birth Date: _____ Relationship: _____

Email: _____ Home Number: _____ Cell Number: _____

Employed By: _____ Occupation: _____

SPOUSE'S INFORMATION:

Name: _____ Marital Status: _____

Home Address: _____

Social Security Number: _____ Birth Date: _____ Relationship: _____

Email: _____ Home Number: _____ Cell Number: _____

Employed By: _____ Occupation: _____

Emergency Contact Info:

Name: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

Patient's/Parent/Guardian Signature: _____ **Date:** _____

Health Questionnaire

Patient's Name: _____ Birth Date: _____

Date of Last Dental Visit: _____ Family Physician: _____

Have you ever had the following?

Orthodontic Consultation: Y/N Date: _____ Dr. _____

Orthodontic Treatment: Y/N Date: _____ Dr. _____

Do you have or have you had any of the following oral conditions?

Y	N	Sensitive teeth	Y	N	Bleeding gums	Y	N	Oral habits (thumb sucking, etc)
Y	N	Clenching or grinding	Y	N	Pain around ear	Y	N	Pain in the jaw, face
Y	N	Jaw joint sounds or pain	Y	N	Pain when opening mouth	Y	N	Mouth breathing
Y	N	Bad breath	Y	N	Dry mouth	Y	N	Inability to floss between teeth
Y	N	Poorly functioning teeth	Y	N	Food wedging between teeth	Y	N	Tobacco use
Y	N	Discolored teeth	Y	N	Swelling or lumps in the mouth			

Do you have or have you had any of the following medical conditions?

Y	N	Rheumatic fever	Y	N	Congenital heart lesions/murmur	Y	N	Heart condition
Y	N	Diabetes	Y	N	Arthritis, swollen joints	Y	N	Tuberculosis
Y	N	Kidney problems	Y	N	Swallowing problems	Y	N	Nose Bleeds
Y	N	Asthma	Y	N	Inflammatory Rheumatism	Y	N	Convulsions or seizure
Y	N	Liver disease	Y	N	Severe headaches	Y	N	Sinus problems
Y	N	Yellow jaundice	Y	N	High blood pressure	Y	N	Low blood pressure
Y	N	Hepatitis type____	Y	N	Ear problems	Y	N	Anemia
Y	N	Easy bruising	Y	N	Speech problems	Y	N	HIV positive
Y	N	ADD/ADHD						

Is patient allergic to latex, metal or vinyl? If yes, please explain: _____

Is patient currently under a physician's care? If yes, please describe _____

Has patient ever been hospitalized or had any serious illness? If yes, please describe _____

Does patient have any drug allergies? If yes, list medications _____

Is patient taking any medications? If yes, list medications _____

Does patient have any food allergies? If yes, please Explain: _____

Female patients – could patient possibly be pregnant at the present time? _____

Has patient ever taken any medication for osteoporosis? _____

Patient's/Parent/Guardian Signature: _____ **Date:** _____