

Welcome to Our Office!

A B C

PATIENT INFORMATION

Date _____

Patient's Name _____
Last First MI School _____

Address _____
Street City State Zip _____

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

RESPONSIBLE PARTY INFORMATION

Name _____
Last First MI Marital Status _____

Residence _____
Street City State Zip _____

Mailing Address _____
Street City State Zip _____

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First MI Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Responsible Party's Email Address _____

INSURANCE

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual Coverage? Yes No If YES:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent or Guardian's signature if minor) _____ Date _____

Updates (Date & Initial) _____

Other family members being treated/in-treatment _____

45-939 Kamehameha Hwy., Suite 103
Kaneohe, HI 96744
(808) 247-6039

1580 Makaloa St., Suite 730
Honolulu, HI 96814
(808) 943-1101

76-6225 Kuakini Hwy., D-101
Kailua-Kona, HI 96740
(808) 329-7551



ERROL Y. W. YIM
DDS, MS, INC • ORTHODONTIC SPECIALIST

MEDICAL HISTORY

MEDICAL RELEASE

	YES	NO
Does the patient have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient sensitive to any drug or medication?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what drug?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient wear contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient had any serious illnesses or condition requiring a physician's care or hospitalization?.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, please explain _____		

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

Diabetes	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	Liver Involvement.....	<input type="checkbox"/>
Rheumatic Feber.....	<input type="checkbox"/>	Kidney Involvement.....	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>
Bone Disorders.....	<input type="checkbox"/>	Emotional Problems.....	<input type="checkbox"/>	Jaundice.....	<input type="checkbox"/>
Hyper Activity	<input type="checkbox"/>	Endocrine Problems.....	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Prolonged Bleeding.....	<input type="checkbox"/>	Herpes Simplex.....	<input type="checkbox"/>
				AIDS or HIV infection	<input type="checkbox"/>

Physician _____

List any drugs or medications now being taken. Give reasons: _____

DENTAL HISTORY

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Has patient ever sucked thumb or fingers? Until what age? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Does the patient breathe predominantly through the mouth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Does the patient have any speech problems?</p> <p><input type="checkbox"/> <input type="checkbox"/> Does the patient clench or grind teeth (at night)?</p> <p><input type="checkbox"/> <input type="checkbox"/> Does the patient have pain or clicking upon closing the mouth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Has the patient had any severe head or face injuries?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have any teeth been chipped due to accidents?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you been informed of missing permanent teeth?</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you been informed of any extra teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Were any teeth (baby or permanent) removed by extraction?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was it suggested that the space be maintained?</p> <p><input type="checkbox"/> <input type="checkbox"/> Was an appliance placed to maintain the space?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you ever had any previous orthodontic consultation or treatment?</p> <p><input type="checkbox"/> <input type="checkbox"/> Is the patient adopted?</p> <p><input type="checkbox"/> <input type="checkbox"/> Does anyone in family have similar dental condition?</p> <p><input type="checkbox"/> <input type="checkbox"/> Would patient mind wearing "braces"?</p> <p><input type="checkbox"/> <input type="checkbox"/> Any noticeable difficulty in chewing or swallowing food?</p>
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Have x-rays of teeth been taken? Yes No If YES, when? _____ Full Mouth? Yes No

By whom? _____