**JOSEPH Y. DE JESUS, D.D.S., P.S.**
**3242 Capitol Blvd. Olympia, WA 98501**
**(360) 943-4531**

Date _____

**PATIENT INFORMATION**

Name _____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____

Date of Birth _____ _____

Employed by _____ _____

Spouse's Name _____ _____

Employed by _____ Phone Number _____

Family Dentist _____ Referred by _____

**INSURANCE INFORMATION**

Do you have orthodontic insurance? _____ Yes _____ No

Insured's Name _____

Insurance Company _____

Group # _____ Insurance ID# _____

Social Security # _____

Date of Birth _____

Insured's Name _____

Insurance Company _____

Group # _____ Insurance ID# _____

Social Security # _____

Date of Birth _____

There is no charge for an initial exam unless x-rays or other diagnostic records are taken.

Signature _____

## MEDICAL HISTORY

Are you in good health? ..... Yes _____ No _____

Are you under treatment by a physician? ..... Yes _____ No _____

Are you taking medication (anti-osteoporosis, etc)? ..... Yes _____ No _____

If yes, explain _____

_____

Do you have any allergies **(latex)** or drug reactions? ..... Yes _____ No _____

If yes, explain _____

_____

Do you now or have you ever in your life, had any of the following: Heart Condition, Rheumatic Fever, Diabetes, Hepatitis, Epilepsy, AIDS, Blood Transfusions, Psychological or Emotional Problems, Headaches (Frequent), Bleeding Tendencies, Tuberculosis, Lupus or Other

..... Yes _____ No _____

If yes to any, please circle and explain _____

_____

Do you have any artificial joints? ..... Yes _____ No _____

Female - Are you pregnant? ..... Yes _____ No _____

Name of family physician _____

## DENTAL HISTORY

When was your last visit to the dentist? _____

The following are some habits occasionally found. Please indicate if it applies.

Thumb Sucking until age _____ Mouth Breathing _____

Finger Sucking until age _____ Tongue Thrusting _____

Lip Biting or Sucking _____ Other Habits _____

Has speech or tongue thrust correction been received? _____

Any injuries to teeth, mouth, or head? _____

Are you aware of any tooth grinding? ..... Yes _____ No _____

Are you aware of any jaw clenching? ..... Yes _____ No _____

Are you aware of any jaw clicking or locking? ..... Yes _____ No _____

Are you aware of any jaw pain? ..... Yes _____ No _____

What is your primary concern (Why are you here?) _____

_____

_____

Have you ever had braces or a retainer? _____

Has anyone in your family been treated by Dr. de Jesus? _____