

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

Date _____

PATIENT INFORMATION

Name _____ Nickname _____ M ___ F ___
Home Address _____ City _____
State _____ Zip _____ Home Number _____
Age _____ Birthdate _____ School _____ Grade _____
Family Dentist _____ Referred by _____

RESPONSIBLE PARTY INFORMATION

FATHER _____ Phone Number H: _____ C: _____
Address _____ City _____ State _____ Zip _____
Employed by _____ Phone Number W: _____
Social Security # _____ Date of Birth _____

MOTHER _____ Phone Number H: _____ C: _____
Address _____ City _____ State _____ Zip _____
Employed by _____ Phone Number W: _____
Social Security # _____ Date of Birth _____

LEGAL GUARDIAN (if necessary)

Name _____ Phone Number H: _____ C: _____
Address _____ City _____ State _____ Zip _____
Employed by _____ Phone Number W: _____
Social Security # _____ Date of Birth _____

PERSON FINANCIALLY RESPONSIBLE

Name _____ Phone Number H: _____ C: _____
Address _____ City _____ State _____ Zip _____
Employed by _____ Phone Number W: _____
Social Security # _____ Date of Birth _____

INSURANCE INFORMATION

Insured Parent's Name _____ Insured Parent's Name _____
Insurance Co. _____ Insurance Co. _____
Group # / Insurance ID# _____ Group # / Insurance ID# _____

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

Signature (Parent's signature if minor) _____

MEDICAL HISTORY

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

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

Are you taking medication?..... 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 commonly 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? _____