E LINE ORTHODONTICS, PLLC

YOON H. CHANG, DDS, MS

Patient's Name: (Mr. Mrs. Miss Dr.)First _____ Last _____

Gender: M F DOB _____/_____/_____ Age: _____ Social Security Number: _____

Home Address: Street_____

City , State & Zipcode _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Cel. Phone Provider _____

Email:_____

School Attending: _____ Hobbies/Interests: _____

Occupation: _____ Work Phone: (_____)_____

Name of family dentist: _____

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

<Account Responsible Party>

First Name: _____ Last Name: _____

Gender: M F Relationship with patient: _____ DOB: _____/____ /____ SSN: _____

Home Address: _____

Cell Phone: (_____)_____Email:_____

<Insurance>

Insurance Carrier: _____ Name of Policy Holder: _____

Policy Number: _____ Group Number: _____

Ortho Coverage: Y N Max _____ Age limit _____ Deductible _____

*** Initial Consultation/Exam fee: Free
***Duplication of record request must be made in writing. Record Duplication fee : refer to fee schedule

The Adult/Guardian who brings in a minor will be responsible for all copayments and deductibles. Your signature below indicates that You understand accept this policy. You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

Signature: _____ Date: _____

Member American Association of Orthodontists

E Line Orthodontics, PLLC
2680 Old Denton Rd Ste 108
Carrollton, TX 75007

Tel. 972-242-2040
Fax. 972-242-7131
www.elineortho.com

E LINE ORTHODONTICS, PLLC

YOON H. CHANG, DDS, MS

Medical/Dental History

Name of Medical Doctor: _____ City/State: _____

List all medications you are now taking:

_____

Are you allergic to any of the following?

Y	N	
☐	☐	Local Anesthetic
☐	☐	Aspirin
☐	☐	Latex (Gloves, Balloons)
☐	☐	Ibuprofen
☐	☐	Penicillin
☐	☐	Pollens
☐	☐	Animals
☐	☐	Other: _____

Do you have any of these medical conditions?

Y	N	
☐	☐	AIDS/HIV Positive
☐	☐	Anemia
☐	☐	Arthritis/Gout
☐	☐	Asthma
☐	☐	Birth Defects or Hereditary Problem
☐	☐	Blood Disease
☐	☐	Blood Transfusion
☐	☐	Breathing Problem
☐	☐	Bruise Easily
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Chest Pains
☐	☐	Cold Sores/Fever Blisters
☐	☐	Congenital Heart Disorder
☐	☐	Diabetes
☐	☐	Drug Addiction
☐	☐	Emphysema
☐	☐	Epilepsy or Seizures
☐	☐	Fainting Spells/Dizziness
☐	☐	Frequent Headaches/Migraines
☐	☐	Hay Fever
☐	☐	Heart Attack/Failure
☐	☐	Heart Murmur
☐	☐	Heart Disease
☐	☐	Hepatitis A
☐	☐	Hepatitis B or C
☐	☐	High or Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Hives/Rash
☐	☐	Hypoglycemia
☐	☐	Immune System Problems
☐	☐	Kidney Problems
☐	☐	Leukemia
☐	☐	Liver Disease
☐	☐	Lung Disease
☐	☐	Mental Health Disturbance or Depression
☐	☐	Osteoporosis
☐	☐	Parathyroid Disease
☐	☐	Polio, Mononucleosis, Pneumonia
☐	☐	Radiation Treatments
☐	☐	Rheumatic Fever
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Trouble
☐	☐	Skin Disorder
☐	☐	Stomach/Intestinal Disease
☐	☐	Stroke
☐	☐	Swelling of Limbs
☐	☐	Thyroid Disease
☐	☐	Tuberculosis
☐	☐	Tumors
☐	☐	Vision or Hearing Problem
☐	☐	Yellow Jaundice
☐	☐	Pregnant/Trying to Become Pregnant

Other Conditions: _____

BP: _____/_____

Do you have any of the following dental conditions?

Y	N	
☐	☐	Pain in Jaw Joints
☐	☐	Any Injuries o Face, Head, Neck
☐	☐	Permanent or Extra Teeth Removed
☐	☐	Extra or Congenitally Missing Teeth
☐	☐	Chipped or Injured Teeth
☐	☐	Any Sensitive of Sore Teeth
☐	☐	Bleeding Gums, Bad Taste or Mouth Odor
☐	☐	Breathing Problem
☐	☐	Abnormal Swallowing
☐	☐	Jaw Fractures, Cysts, Infections
☐	☐	"Gum Boils," Frequent Canker Sores
☐	☐	History of Speech Problems or Therapy
☐	☐	Difficulty Breathing Through Nose
☐	☐	Food Impaction Between the Teeth
☐	☐	Mouth Breathing Habit or Snoring
☐	☐	Frequent Oral Habits
☐	☐	Teeth Causing Irritation
☐	☐	Tooth Grinding or Clenching
☐	☐	Clicking, Locking in Jaw Joints
☐	☐	Soreness in Jaw or Face Muscles
☐	☐	Ringing in Ears
☐	☐	Treated for "TMJ" or "TMD" Problems
☐	☐	Any Broken or Missing Fillings
☐	☐	Trouble with Previous Dental Treatment
☐	☐	Gum Disease or Pyorrhea
☐	☐	Previous Orthodontic Consultation or Treatment

Other Conditions: _____

Signature: _____ Date: _____

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