# Jianjun Hao, DDS, MS, PhD

*Practice Limited to Orthodontics, Dentofacial Orthopedics, and TMJ Dysfunctions*

4949 Euclid Avenue, Suite A Palatine, Illinois 60067

VOICE: 847 397-1111 FACSIMILE: 847-397-1142


***THANK YOU*** *for coming to our office for your orthodontic care. In order for us to properly evaluate your dental and medical health, we request you to fill out **all** parts of this history form. Before any treatment or diagnostic procedures begin, we will inform you of our standard office practices and give you an opportunity to ask questions.*

## GENERAL INFORMATION

| | | | |
|---|---|---|---|
| DR. MISS PATIENT NAME FIRST MIDDLE LAST<br>MR. MS.<br>MRS. | | BIRTH DATE | SOCIAL SECURITY # |
| DR. MISS NAME OF RESPONSIBLE PARTY - IF DIFFERENT FROM ABOVE<br>MR. MS. | DRIVERS LICENSE # | STATE | SOCIAL SECURITY # |
| RESIDENCE ADDRESS NUMBER STREET | | | DATE OF BIRTH |
| CITY STATE ZIP | | EMAIL | |
| WORK PHONE HOME PHONE CELL PHONE | | FULL TIME STUDENT YES ☐ NO ☐<br>WHERE | |
| OCCUPATION OF RESPONSIBLE PARTY | EMPLOYER | | |
| BUSINESS ADDRESS NUMBER STREET | | | |
| CITY STATE ZIP | | | |
| IN CASE OF EMERGENCY, PERSON TO NOTIFY (Not Living With You) | | RELATIONSHIP | |
| WORK PHONE HOME PHONE CELL PHONE | | | |
| HOW WERE YOU REFERRED TO US? | | | |

_____I have been offered a copy of Meadows Dental Care (MDC) Notice of Privacy Practices. I understand that MDC has the right to change its Notice of Privacy Practices from time to time and that I may contact MDC at any time to obtain a current copy of the Notices of Privacy Practices.

_____I authorize the release of my dental health information to my dental insurance companies. I hereby authorize payment directly to Meadows Dental Group, Ltd. of the group insurance benefits otherwise payable to me.

_____I understand and agree that I will be responsible to pay for missed appointment or insufficient cancellation notice fees of $50.00 per instance, and/or late charge fees of 1½ % per month/18 % per annum

_____I understand and agree in the event that this account goes past due and we are forced to use an outside collection agency or law firm, up to 30 % of the balance will be added as collection/ attorney's fees.

_____I understand and agree that if we are forced to file a lawsuit to collect the outstanding balance, you will be liable for all court costs whether judgment has been entered or not.

Signature_____Date_____

## BENEFIT SECTION

| | | | |
|---|---|---|---|
| NAME OF INSURANCE COMPANY | | | GROUP NUMBER |
| ADDRESS OF INSURANCE COMPANY NUMBER STREET | | | INS ID# |
| CITY STATE ZIP | | | |
| EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST | | DATE OF BIRTH | EMPLOYEE/SUBSCRIBER SOC. SEC.# |
| EMPLOYEE SUBSCRIBER MAILING ADDRESS | CITY | STATE | ZIP |
| EMPLOYER (COMPANY) NAME AND ADDRESS | | | |
| IS PATIENT COVERED BY ANOTHER DENTAL PLAN? | DENTAL PLAN NAME | GROUP NO. | INS ID # |
| EMPLOYEE/SUBSCRIBER FIRST MIDDLE LAST | | EMPLOYEE/SUBSCRIBER SOC. SEC.# | RELATIONSHIP TO EMPLOYEE<br>SELF SPOUSE CHILD OTHER<br>☐ ☐ ☐ ☐ |
| EMPLOYER (COMPANY) NAME AND ADDRESS | | | DATE OF BIRTH |

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# DENTAL HISTORY

Purpose of this appointment:

[ ] Orthodontic Treatment Braces [ ] Orthodontic Treatment Invisalign

[ ] Orthodontic Treatment 2nd Opinion [ ] OTHER_____

Dentist name: _____Phone: _____

Date of last Dental Exam: _____

| | |
|---|---|
| Are you presently in any dental pain? | [ ] YES [ ] NO |
| Have you ever injured your face, mouth, or teeth? | [ ] YES [ ] NO |
| Have you ever been told or noticed if you have bad breath? | [ ] YES [ ] NO |
| Do you habitually breathe through your mouth? | [ ] YES [ ] NO |
| Do you snore? | [ ] YES [ ] NO |
| Do you have allergies which cause you to have a stuffed nose? | [ ] YES [ ] NO |
| Do you have any oral habits such as digit sucking, nail biting, or chewing on pens? | [ ] YES [ ] NO |
| Do you catch food between any of your teeth? | [ ] YES [ ] NO |
| Do your gums bleed when brushing or flossing? | [ ] YES [ ] NO |
| Have you ever been told you have gum disease, gingivitis, or periodontitis? | [ ] YES [ ] NO |
| Are any of your teeth sensitive? | [ ] YES [ ] NO |
| IF YES, to what are they sensitive? | [ ] HOT [ ] COLD [ ] SWEETS [ ] CHEWING |
| Do you clench or grind your teeth? | [ ] YES [ ] NO |
| Are your jaws ever sore or tired? | [ ] YES [ ] NO |
| How frequently do you get headaches? | [ ] Every day [ ] 1 per week [ ] 1 -2 per month |
| Has anyone in your family had orthodontic treatment? | [ ] YES [ ] NO |

How frequently have you returned for dental checkups in the past?

[ ] Every 3 mos. [ ] Every 4 mos. [ ] Every 6 mos [ ] Every 12 mos.

Do you have any other dental issues, questions, or concerns?

_____

_____

_____

_____

_____

The benefits of Orthodontic Treatment include Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in general and long term dental health, in the general function of the teeth, and in the appearance of the teeth and smile. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and swollen or infected gums can result. Jaw joint (TMJ) discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

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Primary care
Physician_____ Date of Last Visit _____

## Please check Yes or No (If Yes, please fill in details)

[ ] YES [ ] NO Are you taking any medication? _____

[ ] YES [ ] NO Are you allergic to any medication? _____

[ ] YES [ ] NO Do you have any allergies? _____

[ ] YES [ ] NO Have you been sick or hospitalized in the last five years? If YES, Why?

_____

_____

[ ] YES [ ] NO Are you currently under the care of a physician? If YES, Why?

_____

_____

## Circle any of the medical conditions below that you have had or currently have.

[ ] Abnormal bleeding/Hemophilia
[ ] Anemia
[ ] Arthritis
[ ] Asthma or Hay fever
[ ] Bone Disorders
[ ] Cancer
[ ] Congenital Heart Defect
[ ] Diabetes
[ ] Dizziness
[ ] Epilepsy
[ ] Gastrointestinal Disorders
[ ] Heart Murmur
[ ] Heart Problems
[ ] Heart Murmur
[ ] Hepatitis/Liver problems
[ ] High Blood Pressure
[ ] HIV / Aids
[ ] Kidney problems
Herpes
[ ] Nervous Disorders
[ ] Osteoporosis
[ ] Pneumonia
[ ] Prolonged Bleeding
[ ] Radiation/Chemotherapy
[ ] Rheumatic Fever
[ ] Tuberculosis
[ ] Tumor or Cancer

Do you have any other medical conditions we should be aware of?

_____

_____

_____

_____ _____ _____

Signature of patient or legal guardian Please Print Your Name Date

Relationship to patient: _____