CONSULT FORM

LONG BEACH ORTHODONTICS
DAVID WU D.D.S. P.C.

Today's Date _____

Name of Patient _____ Birthdate _____

Home telephone number _____ Cell phone _____

Street address of patient _____ Town _____

E-mail address _____ Zip code _____

Medical History of patient _____

Is patient taking any medications? _____

Does patient have any mouth Habits such as:
Thumb sucking; finger sucking; mouth breathing; nail biting; biting on foreign objects, etc
Other: _____

Is patient a full time student? _____ School _____

If employed, where does patient work? _____ phone _____

If patient is under the age of 21, please provide the following information:

Father's name _____
Mother's name _____
Marital status of parents: married - separated - divorced

Father's place of employment _____
Work phone _____ extension _____
Mother's place of employment _____
Work phone _____ extension _____

Name of person responsible for professional fees _____
Address of responsible party _____

Is patient covered by dental insurance? _____
If yes, name of insurance company or group _____
Social Security number of policy holder _____
Birthdate of policy holder _____

Name of patient's general dentist _____
Approximate date of last visit to patient's general dentist _____

Who referred patient to this office? _____
If there are any other facts or information, not covered on this form, of which you would like to inform the office, please use this space: