Chiang
ORTHODONTICS

Patient Information

Date _____ Male ☐ Female ☐

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birthdate _____ Age _____ S.S.# _____

School _____ Grade _____ Dentist _____ Phone _____

If patient is a minor, give parents' or guardian's name _____

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

Do you have any friends or family that are patients in our office? _____

Responsible Party

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Primary Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Secondary Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Emergency Information

Name of nearest relative or friend _____ (Relationship) _____

Complete Address _____ (Street) _____ (City) _____ (State) _____ (Zip) _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (Date & Initial) _____

OVER

Medical History

Physician's Name _____ Phone # _____ Date of last physical exam _____

Has the patient ever been treated for or had symptoms of any of the following medical conditions?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Any heart problems	☐	☐	Allergies to anesthetics	☐	☐	Diabetes	☐	☐	Scarlet Fever
☐	☐	High blood pressure	☐	☐	Allergies to medicines or drugs	☐	☐	Hepatitus	☐	☐	Sinus Problems
☐	☐	Low blood pressure	☐	☐	Allergies to _____	☐	☐	Headaches	☐	☐	Stroke
☐	☐	Circulatory problems	☐	☐	Anemia	☐	☐	Measles	☐	☐	Typhoid Fever
☐	☐	Nervous problems	☐	☐	Arthritis	☐	☐	Mumps	☐	☐	Tonsilitis
☐	☐	Radiation treatments	☐	☐	Asthma	☐	☐	Psychiatric care	☐	☐	Ulcer
☐	☐	Excessive bleeding	☐	☐	ADHD	☐	☐	Rheumatic Fever	☐	☐	Venereal Disease
☐	☐	Snoring				☐	☐	Difficulty waking up			

Are you pregnant? _____

Are you now taking any medications? If yes, give reason: _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment _____

_____

_____

_____

Dental History: Check (✓) any of the following that apply

Does the patient presently:

YES	NO	
☐	☐	Suck a thumb?
☐	☐	Chew pencils or pens?
☐	☐	Breath through the mouth?
☐	☐	Have a speech problem?
☐	☐	Show apprehension toward dentists?
☐	☐	Play a musical wind instrument?

Has the patient ever had:

YES	NO	
☐	☐	Any abscessed teeth?
☐	☐	Any teeth injured in an accident?
☐	☐	Any severe head or face injury?
☐	☐	Any extra teeth?
☐	☐	Any missing permanent teeth?

Approximate date of last dental examination _____

_____

TMJ History

(1) Do you experience any popping, cracking or pain in the jaw joints? ☐ Yes ☐ No

(2) Do you experience tightness in the jaw joint? ☐ Yes ☐ No

(3) Do you have difficulty in opening wide or chewing? ☐ Yes ☐ No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.