Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

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

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

Responsible Party Information

Name _____ _____
Last First Middle Martial 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 _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

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

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If yes:

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

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

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Bernard C. Chang, D.D.S., M.S. **Orthodontics**

Health History

What are the main concerns that you would like orthodontics to accomplish?

_____

Dental History

General Dentist _____ Telephone _____

Have you ever been evaluated or had orthodontic treatment before?	Yes	No
Have there been any injuries to the face, mouth, teeth or chin?	Yes	No
Do you now or have you ever experienced pain/discomfort in you jaw joint (TMJ)?	Yes	No
Do you like your smile?	Yes	No
Do your gums ever bleed?	Yes	No
Do you have any speech problems?	Yes	No
Do you have any missing or extra permanent teeth?	Yes	No
Do you generally breathe through your mouth?	Yes	No

Medical History

Please describe your current physical health: Good Fair Poor

Physician's name _____ Phone #: _____ Are you currently under the care of a physician? Yes No

Please list all drugs that you are currently taking: _____

For Women: Are you taking birth control pills?	Yes	No
Are you pregnant?	Yes	No
Are you nursing?	Yes	No

Have you ever had any of the following medical problems? (please circle)

Anemia/Radiation Treatment	Yes	No	Heart Surgery/Pacemaker	Yes	No
Artificial Bones/Joints	Yes	No	Hemophilia/Abnormal Bleeding	Yes	No
Artificial Valves	Yes	No	Hepatitis	Yes	No
Asthma/Arthritis	Yes	No	High/Low Blood Pressure	Yes	No
Blood Transfusion	Yes	No	HIV+/AIDS	Yes	No
Cancer/Chemotherapy	Yes	No	Hospitalized	Yes	No
Congenital Heart Defect	Yes	No	Kidney/Liver problems	Yes	No
Diabetes/Tuberculosis	Yes	No	Mitral Valve Prolapse	Yes	No
Difficulty Breathing	Yes	No	Psychiatric Problems	Yes	No
Drug/Alcohol Abuse	Yes	No	Rheumatic/Scarlet Fever	Yes	No
Emphysema/Glaucoma	Yes	No	Severe/Frequent Headache	Yes	No
Epilepsy/Seizures	Yes	No	Shingles	Yes	No
Fever Blisters/Herpes	Yes	No	Sinus Problems	Yes	No
Heart Attack/Stroke	Yes	No	Ulcers/Colitis	Yes	No
Heart Murmur	Yes	No	Venereal Disease	Yes	No

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following? (please circle)

Aspirin	Yes	No	Latex	Yes	No
Any Metal/Plastic	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Tetracycline	Yes	No
Dental Anesthetics	Yes	No	Other	Yes	No
Erythromycin	Yes	No			

Please list any other drugs that you are allergic to: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date