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 _____

Orthodontic 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.

Health History

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

_____

_____

Has your child ever been evaluated or had orthodontic treatment before? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: _____

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Does your child floss his/her teeth daily? Yes No

Child's Physician: _____ Child's Dentist: _____

Phone#: _____ Date of last Visit: _____

Is your child currently under the care of a physician? Yes No

Has puberty begun? Yes No

Has menstruation begun? (girls) Yes No

Please describe your child's current physical health: Good Fair Poor

Please list all the drugs your child is currently taking: _____

Please list all drugs/things that your child is allergic to: _____

Has your child ever had any of the following medical problems? (please circle)

Abnormal Bleeding	Yes	No	Diabetes	Yes	No
Allergies to any drugs	Yes	No	Handicaps/Disabilities	Yes	No
Allergic to Latex/Metal	Yes	No	Hearing Impairment	Yes	No
Allergic to Plastic	Yes	No	Heart Murmur	Yes	No
Any Hospital Stays	Yes	No	Hemophilia	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No
Cancer	Yes	No	HIV+/AIDS	Yes	No
Congenital Heart Defect	Yes	No	Kidney/Liver Problems	Yes	No
Convulsions/Epilepsy	Yes	No	Rheumatic/Scarlet Fever	Yes	No
			Tuberculosis (TB)	Yes	No

Please discuss any medical problems that your child has had: _____

_____

Does your child have any of the following habits? (please circle)

Clenching/Grinding teeth	Yes	No	Nurse bottle habits	Yes	No
Lip Sucking/Biting	Yes	No	Speech Problems	Yes	No
Mouth Breathing	Yes	No	Thumb/Finger Sucking	Yes	No
Nail Biting	Yes	No	Tongue Thrust	Yes	No

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 child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of parent or guardian Date Reviewed by Date