RICHARD CHAN
ORTHODONTICS

CONFIDENTIAL PATIENT INFORMATION

Patient's Name:_____ Nickname:_____

Address:_____ CITY _____ STATE/ZIP _____

Home Phone:_____ Social Security #: _____

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

School:_____ Birthdate: _____ Age:_____

Sports/Musical Instruments/Hobbies:_____

Names of brothers and sisters:_____ Ages:_____

Confidential Responsible Party Information

Name: LAST _____ FIRST _____ MIDDLE _____ Marital Status:_____

Residence:_____ CITY _____ STATE/ZIP _____

How many years at this residence? _____ Home Phone:_____ Work Phone_____

Mailing Address (if different from residence):_____ CITY _____ STATE/ZIP _____

Previous Address (if less than 3 yrs): _____ CITY _____ STATE/ZIP _____

Cell Phone: _____ Social Security #: _____

Email Address: _____ Birthdate: _____ Relationship To Patient:_____

Employer:_____ Occupation:_____ No. Years Employed:_____

Spouse's name:_____ Relationship To Patient:_____

Social Security #: _____ Birthdate:_____ Work Phone:_____

Employer:_____ Occupation:_____ No. Years Employed:_____

Cell Phone:_____ Email Address:_____

Dental Insurance Information **-Please bring cards to appointment**

Primary Dental Insurance

Policy Holder's Name:_____ Soc. Sec. #:_____ Date of Birth:_____

Dental Ins Co:_____ Group No:_____ Local No._____

Insurance Co. Address: _____ CITY _____ STATE/ZIP _____

Insurance Co. Phone No:_____ Policy Holder's Employer:_____

Relationship to Patient:_____ Policy Holder's ID #:_____

Do you have dual dental coverage? (circle one) ○YES ○NO

Secondary Dental Insurance

Policy Holder's Name:_____ Soc. Sec. #:_____ Date of Birth:_____

Dental Ins Co:_____ Group No:_____ Local No._____

Insurance Co. Address: _____ CITY _____ STATE/ZIP _____

Insurance Co. Phone No:_____ Policy Holder's Employer:_____

Relationship to Patient:_____ Policy Holder's ID #:_____

Emergency Information

Name of nearest relative not living with you:_____ Relationship to Pt:_____

Complete Address:_____ CITY _____ STATE/ZIP _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Orthodontic History

PLEASE ANSWER ALL QUESTIONS FOR THE PATIENT IF HE/SHE IS A MINOR AND FOR YOURSELF IF YOU ARE THE PATIENT.

Describe in your own words what you understand the orthodontic problem to be:_____

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

Is this your first orthodontic evaluation?_____

Has anyone in the family received orthodontic treatment by another orthodontist?_____

How did they feel about the result?_____

Names of any family members we have treated_____

What is your attitude toward receiving orthodontic treatment?_____

Dental History

Dentist:_____ Date of last visit:_____

Address:_____ Phone:_____

O Yes O No Have you ever had a bad experience in a dental office? Describe:_____

_____

O Yes O No Have you ever chipped or lost any teeth?_____

O Yes O No Have there been any injuries to your face, mouth, or teeth?_____

O Yes O No Is any part of your mouth sensitive to temperature or pressure?_____

O Yes O No Do your gums bleed when you brush?_____

O Yes O No Do you have any type of thumb or tongue habit?_____

O Yes O No Are you a mouth breather?_____

O Yes O No Have your tonsils and/or adenoids been removed? At what age?_____

O Yes O No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____

O Yes O No Are you aware of your jaw clicking or popping?_____

O Yes O No Are you aware of clenching your teeth during the day?_____

O Yes O No Have you ever been told that you grind your teeth at night?_____

O Yes O No Do you have "tension" headaches?_____

O Yes O No Have you ever experienced chronic ringing in your ears?_____

O Yes O No Have you ever been told you have TMJ problems?_____

Medical History

Physician:_____ Date of Last Visit:_____ Weight:_____

Address:_____ Phone:_____

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

O Yes O No Are you taking any medication?_____

O Yes O No Are you allergic to any medication?_____

O Yes O No Are you allergic to any metal or latex?_____

O Yes O No Have you ever had a major illness?_____

O Yes O No Have you had any major operations?_____

O Yes O No Have you ever been involved in a serious accident?_____

O Yes O No Have you ever taken any Bisphosphonates? *If so, please list:*_____

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

☐ Abnormal bleeding/Hemophilia	☐ Diabetes	☐ Hepatitis/Liver Problems	☐ Pneumonia
☐ Anemia	☐ Dizziness	☐ Herpes	☐ Prolonged Bleeding
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Radiation/Chemotherapy
☐ Asthma or Hayfever	☐ Gastrointestinal disorders	☐ HIV + / AIDS	☐ Rheumatic Fever
☐ Bone Disorders	☐ Heart Problems	☐ Kidney Problems	☐ Tuberculosis
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Nervous disorders	☐ Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?_____

X Signature (Parent's Signature if minor)_____ Date:_____

I have read and understand the above questions. I will not hold Dr. Chan or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform Dr. Chan and Staff. I give my permission for my x-rays, models and photographs to be used by Richard Chan Orthodontics for the purposes of education, lectures, training, and promotion. I also understand that where appropriate, credit bureau reports may be obtained.