



WELCOME

SO THAT WE MIGHT BECOME BETTER ACQUAINTED,
PLEASE COMPLETE THE FOLLOWING.



Patient Information

Date _____ Birthdate _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ - _____ Cell _____ - _____ Mom Dad Other _____

E-mail Address _____ Other family members in our practice _____

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

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

Responsible Party Information

Name _____
LAST FIRST MIDDLE MARITAL STATUS

Address _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address? _____ Own Rent

Previous Address _____
(IF LESS THAN 3 YEARS) STREET CITY STATE ZIP

Social Security # _____ - _____ - _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
LAST FIRST MIDDLE

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ - _____ - _____ Birthdate _____ Relationship to Patient _____

Insurance Information

A

Subscriber's Name _____ Subscriber's ID # _____

Insurance Company _____ Insurance Phone # _____ - _____ - _____

Group or Local # _____ Subscriber's Employer _____ Subscriber's Birthdate _____

B (if you have dual coverage)

Subscriber's Name _____ Subscriber's ID # _____

Insurance Company _____ Insurance Phone # _____ - _____ - _____

Group or Local # _____ Subscriber's Employer _____ Subscriber's Birthdate _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____ Phone _____ - _____ - _____

Medical History

Child's Physician _____ City _____ Phone _____ - _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Behavior Problems |
| <input type="checkbox"/> Heart Disease or Murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Slow in Learning |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Eye or Ear Problems | <input type="checkbox"/> Kidney Disease | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Grinding | | |

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

- Under a physician's care at this time? _____
- Taking any medications at this time? Specific: _____
- Any allergies? _____
- Any allergic or unfavorable reactions to any drug or medication? _____

Dental History

Child's Dentist _____ City _____ Phone _____ - _____

Approximate date of last dental visit _____ Reason _____

- Injuries or operations to the face, mouth, or teeth? _____
- Do you know of any missing or extra adult teeth? _____

HAVE YOU OBSERVED THAT YOUR CHILD HAS ANY OF THESE HABITS?

- | | |
|--|--|
| <input type="checkbox"/> Thumb or finger sucking
At this time? If stopped, at what age? _____ | <input type="checkbox"/> Mouth breathing |
| | <input type="checkbox"/> Tongue thrust |
- Has an orthodontist been consulted previously? If so, why are you seeking a second opinion?

Jaw Growth

In some instances, the ability of Dr. Chaison to help guide the growth amount and direction of your child's jaw may be critical to the success of the orthodontic treatment plan. In order to determine your child's jaw growth potential, please answer the following:

Do you feel he/she is still growing?
 Yes No

GIRLS: Has she started menstruation (monthly periods)? Yes No
Approximately when did these changes begin? _____

Patient's current height _____
Mother's height _____
Father's height _____

BOYS: Has his voice changed? Yes No
Started to shave? Yes No
Approximately when did these changes begin? _____

I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. This office reserves the right to verify the credit status of potential patient and/or parents of patients prior to extending credit for treatment fees.

Signature _____ Relationship to Patient _____

Updates (date and initial) _____