CHAISON
ORTHODONTICS
EMI CHAISON
DDS, MS
EMBRACE YOUR SMILE

WELCOME

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

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EMBRACE YOUR SMILE

Patient Information

Date _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Birthdate _____ Social Security ___-___-____

Home Phone ___-___-____ Cell ___-___-____ Work Phone ___-___-____ OK to contact? ☐Yes ☐No

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

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

Physician _____ City _____ Phone ____-____-____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE BEEN TREATED FOR OR MAY BE AT RISK FOR:

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

☐ Have you ever had an allergic reaction to any drug or medication? _____

☐ Have you ever taken bisphosphonates for osteoporosis? _____

Dental History

Dentist _____ City _____ Phone ____-____-____

Approximate date of last dental visit _____ Reason _____

CHECK ANY OF THE FOLLOWING THAT APPLY AND EXPLAIN BELOW:

- ☐ Any injury to the face, mouth, or teeth?
- ☐ Have you ever sucked your thumb or fingers? If so, until what age? ____
- ☐ Do you grind or clench your teeth during the day or night?
- ☐ Do you have any speech difficulty?
- ☐ Do you have any difficulty chewing?
- ☐ Teeth difficult to clean?
- ☐ Pain or noise from jaw joint?
- ☐ Awareness of any gum or bone problems around teeth?
- ☐ Inability to open mouth wide or move jaw normally?
- ☐ Prior orthodontic work or consultation with an orthodontist?
- ☐ Concerned about the appearance of your teeth?
- ☐ Are you concerned about the appearance of your face and/or jaw structure?

Comments:

_____

_____

What is your primary reason for seeking an orthodontic examination?

_____

_____

Has an orthodontist been consulted previously? If so, why are you seeking a second opinion?

_____

_____

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 responsible financial parties prior to extending credit for treatment fees.

Signature _____ Relationship to Patient _____

Updates (date and initial) _____