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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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:

- ☐ 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 _____

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?

- ☐ Thumb or finger sucking
  At this time? If stopped, at what age? _____
- ☐ Mouth breathing
- ☐ 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 voiced 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) _____