Welcome!

Charlene R. Chan, DDS, Inc
Orthodontics & Dentofacial Orthopedics
707.823.1200

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you are able. It is our commitment to help create and enhance beautiful smiles that will last a lifetime!

Member American Association of Orthodontists

Tell us about you

Today's Date _____ Nickname _____

Name _____
Last First MI

Birthdate _____ ☐M ☐F Age _____

Home # ( )_____ Mobile # ( ) _____

Home Address _____
Street

_____ How Long? _____
City State Zip

Email _____

Employer _____ Work # ( ) _____

Employer's Address _____

Occupation _____ How Long? _____

SocSec#_____ DL# _____

Names of other family members seen by us _____

Whom may we thank for referring you? _____

General Dentist _____ Date of Last Visit _____

Spouse/Partner Information

Name _____ Home # ( ) _____

Address _____
Street

_____ How Long? _____
City State Zip

Email _____

Employer _____ Work # ( )_____

Occupation _____ How Long? _____

Marital Status: ☐ Single ☐ Divorced ☐ Partnered ☐ Married ☐ Widowed ☐ Separated

Person Responsible for Account

Name: _____ Relation _____

Billing Address _____
Street

_____
City State Zip

Previous Address _____
Street

_____
City State Zip

Home #)_____ Mobile # ( )_____

Employer _____ Work # ( )_____

SS# _____ DL # _____

Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # ( ) _____

Group# (Plan, Local or Policy#) _____

Insured's Name _____Relation _____

Insured's Birthdate_____ Insured's SocSec#_____

Insured's Employer _____

Employer's Address _____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # ( ) _____

Group # (Plan, Local or Policy#) _____

Insured's Name _____ Relation _____

Insured's Birthdate_____ Insured's SocSec#_____

Insured's Employer _____

Employer's Address _____

Medical History

Please describe your current physical health ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician _____

Phone # ( )_____ Date of Last Visit _____

Women: are you now pregnant? _____months ☐ Yes ☐ No

Please list all drugs that you are is currently taking:_____

_____

Please list all drugs/things that you are allergic to: _____

_____

Have you ever had any of the following medical concerns?

Abnormal Bleeding	☐	Fainting or Dizziness	☐
Anemia	☐	Hearing Impairment	☐
Allergies to any Drugs	☐	Heart Condition	☐
Allergies to Latex/Metals	☐	Hemophilia	☐
Allergies to Plastic	☐	Hepatitis	☐
Artificial Bones/ Joints/Valves	☐	High Blood Pressure	☐
Asthma	☐	HIV / AIDS / ARC	☐
Autoimmune Disease	☐	Kidney Involvement	☐
Bone Disorders	☐	Liver Involvement	☐
Cancer	☐	Nervous Disorders	☐
Convulsions/ Epilepsy/Seizures	☐	Pneumonia	☐
Diabetes	☐	Rheumatic/Scarlet Fever	☐
Difficulty Breathing	☐	Tuberculosis	☐
Endocrine Disorders	☐		

Please explain: _____

_____

_____

Dental History

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

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have you ever been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have you been informed that you have periodontal disease? ☐ Yes ☐ No

Have you had significant experience with any of the following?

Bleeding gums	☐ Yes	☐ No
Clenching / Grinding Teeth	☐ Yes	☐ No
Clicking in the jaw joints	☐ Yes	☐ N
Pain in the jaw joint (TMJ/TMD)	☐ Yes	☐ No
Injuries to the face, mouth or chin	☐ Yes	☐ No
Speech Difficulties	☐ Yes	☐ No
Thumb / Finger Sucking age _____	☐ Yes	☐ No
Tongue Thrust	☐ Yes	☐ No

Dentist _____ Date of last visit_____

Periodontist _____ Oral Surgeon _____

In Case of Emergency

Name of nearest relative _____

Address _____

Home # ( ) _____ Work # ( )_____

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 medical status.

_____ _____

Date Signature

For Office Use Only

Date	Recommendations	Date	Recommendations