Welcome!

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

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as possible. We are committed to creating beautiful, healthy smiles that will last a lifetime!

Tell us about your Child

Today's Date _____ Nickname _____

Child's Name _____
Last First MI

Birthdate _____ ☐M ☐F Age _____

School _____ Grade _____

Hobbies/Sports/ Musical Instruments _____

Child's Home Phone ( ) _____

Child's Home Address _____
Street

_____
City State Zip

Who is Accompanying your Child Today?

Name _____ Relationship _____

Do you have legal custody of this child? ☐ Yes ☐ No

List brothers/sisters with ages _____

_____

Whom may we thank for referring you? _____

General Dentist _____ Date of Last Visit _____

Mother's Information ☐Step Mother ☐Guardian

Name _____ Home# ( ) _____

Address _____ Mobile# ( ) _____
Street

_____ How Long? _____
City State Zip

Email _____

Occupation _____ How Long? _____

Employer _____ Work# ( ) _____

SocSec# _____ DL# _____

Father's Information ☐Step Father ☐Guardian

Name _____ Home# ( ) _____

Address _____ Mobile# ( ) _____
Street

_____ How Long? _____
City State Zip

Email _____

Occupation _____ How Long? _____

Employer _____ Work# ( ) _____

SocSec# _____ DL# _____

Parents 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# ( ) _____ Work# ( ) _____

Employer _____

SocSec# _____ DL# _____

Who is responsible for making appointments? _____

Name: _____ Relation _____

Home#( ) _____ Work# ( ) _____

Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Group # (Plan, Local or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy owner's Birthdate _____ SocSec# _____

Policy Owner's Employer _____

Employer's Address _____

_____

Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Group # (Plan, Local or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy owner's Birthdate _____ SocSec# _____

Policy Owner's Employer _____

Employer's Address _____

_____

Medical History

Please describe your child's current physical health ☐Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's Physician _____

Phone # ( )_____ Date of Last Visit _____

Has puberty begun?
Has voice changed? (Boys) ☐ Yes ☐ No
Has menstruation begun? (Girls) ☐ Yes ☐ No

Has your child ever taken Phen-Fen? ☐ Yes ☐ No
(also known as Redux or Pandoimin) If yes, when?_____

Please list all drugs that your child is currently taking:_____

_____

lease list all drugs/things that your child is allergic to: _____

_____

Has your child ever had any of the following medical concerns?

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

Please discuss any medical concerns that your child has had: _____

_____

_____

_____

_____

Dental History

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

_____

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have there been any injuries to the face, mouth or chin? ☐ Yes ☐ No

Have adenoids/tonsils been removed? Age _____ ☐ Yes ☐ No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/ her teeth daily? ☐ Yes ☐ No

Has your child ever had any of the following?

Clenching / Grinding Teeth	☐
Lip Sucking / Biting	☐
Mouthbreather	☐
Nail Biting	☐
Nursing Bottle Habits	☐
Speech Difficulties	☐
Thumb / Finger Sucking	☐
Tongue Thrust	☐

Until what age? _____

List any musical instruments played _____

Has either parent had orthodontic treatment? ☐ Yes ☐ No

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Name of nearest relative _____

Relationship: _____

Address_____

Phone # ( ) _____

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 child's medical status.

I authorize the orthodontic staff of Charlene R. Chan, DDS, Inc. to perform the services necessary for this examination.

_____

Date Signature of Parent/ Legal Guardian

For Office Use Only

Date	Recommendations	Date	Recommendations