CHAN ORTHODONTICS
CREATING GREAT SMILES

Member American Association of Orthodontists

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Orthodontics & Dentofacial Orthopedics

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 age _____

_____

Whom may we thank for referring you? _____

General Dentist _____ Date of Last Visit _____

Mother's Information ☐**Step Mother** ☐**Guardian**

Name _____ Home# _____

Address _____ Mobile# _____

Email _____

Occupation _____ How Long? _____

Employer _____ Work# _____

SocSec# _____ DL# _____

Father's Information ☐**Step Father** ☐**Guardian**

Name _____ Home# _____

Address _____ Mobile# _____

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 # _____ 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

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? ◯ Yes ◯ No

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:_____

_____

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

_____

_____

Please check any of the following medical concerns your child may have ever experienced:

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

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 ace, 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 Until what age? _____
- ☐ Tongue Thrust

List any musical instruments played _____

Has either parent had orthodontic treatment? ◯ Yes ◯ No

Has your child ever been evaluated or had Orthodontic treatment? ◯ Yes ◯ No

In Case of Emergency

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