DATE: _____

MILTON D. CHAN, D.D.S.
ROZHEH BABAAN, D.D.S.
Orthodontics for Children and Adults

ADULT PATIENT INFORMATION

Patient's Name: _____ Gender _____ Marital Status: _____ Date of Birth: _____
Address: _____ City: _____ State: _____Zip: _____
Telephone: Home: _____ Cell: _____ Work: _____ e-mail address: _____
Responsible Party Name/Address: _____
Referred by: _____Dentist's Name: _____Dentist Phone_____
Resp. Party Employer Employer: _____ Occupation: _____
Emergency Contact:_____Relationship: _____Phone: _____

PATIENT ORTHODONTIC INSURANCE INFORMATION

Are you covered by Orthodontic Insurance Plan? Yes ____ No ____
Subscriber Name: _____Date of Birth: _____ Soc. Sec. # _____
Insurance Company: _____Address: _____
Subscriber ID #: _____Group #: _____

HEALTH INFORMATION

Name of medical doctor: _____Phone: _____
Are you in good health? ..... Yes ____ No ____
Do you have any history of major illness? ..... Yes ____ No ____
During the past two years:
Have you ever been hospitalized? ..... Yes ____ No ____
Have you been under the care of a physician? ..... Yes ____ No ____
If so please state the reason: _____
Check any of the following which you have had or have at present:

___Diabetes	___HIV/AIDS	___Blood Transfusion	___Sinus Problems	___Respiratory Problem
___Pneumonia/TB	___Anemia	___Allergies/hives	___Blood Disorder	___Nervous Disorder
___Heart Trouble	___Asthma	___Kidney/Liver Disease	___Endocrine Problem	___Venereal Disease
___Rheumatic Fever	___Epilepsy	___High Blood Pressure	___Prolonged Bleeding	___Congenital Heart Lesion
___Bone Disorder	___Ulcers	___Hepatitis/Jaundice	___Fainting or Dizziness	___Stomach/Intestinal Problem

Do you have any disease, condition, or problem not listed? ..... Yes ____ No ____
List any drug or medications now being taken: _____
List any allergies or drug sensitivity: _____
Have you ever had any x-ray treatment (other than diagnostic?) ..... Yes ____ No ____
Women: Are you pregnant? ..... Yes ____ No ____
Do you anticipate becoming pregnant? ..... Yes ____ No ____
Have you ever had periodontal disease? ..... Yes ____ No ____
Do your gums bleed? ..... Yes ____ No ____
Do your teeth feel loose? ..... Yes ____ No ____
Do you grind or clench your teeth or jaws during the day or night? ..... Yes ____ No ____
Do you have sore or sensitive teeth? ..... Yes ____ No ____
Do you have pain elsewhere in your face or jaws? ..... Yes ____ No ____
Do you have clicking in the jaw joint? ..... Yes ____ No ____
Have there been any injuries to the face, mouth or teeth? ..... Yes ____ No ____
Did you ever suck a thumb or fingers? Until what age? ..... Yes ____ No ____
Have you been informed of any missing or extra permanent teeth? ..... Yes ____ No ____
Has an orthodontist been consulted previously? ..... Yes ____ No ____
Has either parent had orthodontic treatment? ..... Yes ____ No ____
Check reason for today's visit: Crowding ___ Spacing ___ Missing Teeth ___ Overbite ___ Timing for Treatment ___ Other ___

I have received a copy of this office's Notice of Privacy Policy and consent to the use and disclosure of health information for treatment, payment, and health care operation purposes.

Patient's Signature: _____ Date: _____ Practice witness: _____ Date: _____
Update: Practice witness: Initial/Date: _____ Initial/Date: _____ Initial/Date: _____