DATE: ______________________

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

PATIENT INFORMATION

Patient's Name: ____ Gender ______Age: _____ Date of Birth: ___________________
Address: ____ City: _____________________ State: __________Zip: ______________
Home Phone: ____________________ Patient's Hobbies: ___________________________________ School: ________________________
Referred by: _______________________________________Dentist's Name: ____

RESPONSIBLE PARTY INFORMATION

Father's Name: ____ Soc. Sec. #: _________________________
Address (if different): ____ City: ___________________ Sate: ___ Zip: ___________
Telephone: Home: ______________________ Work: ______________________ Cell: __________________ e-mail: ___________________
Employer: ____ Occupation: ____
Mother's Name: ____ Soc. Sec. #: _________________________
Address (if different): ____ City: ___________________ State: ____ Zip: __________
Telephone: Home: ______________________ Work: ______________________ Cell: __________________ e-mail: ___________________
Employer: ____ Occupation: ____

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 #: ____

PATIENT HEALTH INFORMATION

Name of medical doctor: ____Phone: _____________________________
Is the patient in good health? .... Yes ____ No ____
Does the patient have any history of major illness?.. Yes ____ No ____
Is the patient 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

Does the patient 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 the patient ever had any x-ray treatment (other than diagnostic?) .... Yes ____ No ____
Patient's Height: ____ Weight: ____ .... Yes ____ No ____
Ha the patient reached puberty?
Girls: has she started menstruation? .... Yes ____ No ____
Boys: has his voice changed? .... Yes ____ No ____
Has there been any injuries to the face, mouth or teeth? .... Yes ____ No ____
Has the patient ever sucked a thumb or fingers? .... Yes ____ No ____
Does the patient grind or clench your teeth or jaws during the day or night? .... Yes ____ No ____
Is the patient a mouth breather? While awake?.. Yes ____ No ____
While sleeping?.. Yes ____ No ____
Has the patient 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 ___

Parent's Signature: ___________________________________ Date: _____________ Practice witness: ___________Date_______________
Updates: Practice witness: Date/initials: ___________________ Date/Initials: ___________________ Date/Initials: __________________