cheron orthodontics

We would like to welcome you to our office.
Please complete both sides of this form. All information is confidential. Thank you.

PATIENT INFORMATION Date: _____

Patient's Name: _____ Nickname: _____
Age: _____ Birth Date: _____ Social Security #: _____
Home Address: _____
Home phone: _____ Cell/Work phone: _____ E-Mail: _____
If patient is a minor, give parent or guardian's names: _____
Who may we thank for referring you to our office? _____

IF UNDER 18

School: _____ Grade: _____
Hobbies: _____ Siblings: _____
Has any family member had braces before? If so, who? _____

RESPONSIBLE PARTY

First name: _____ Last Name: _____ MI: _____ Marital Status_____
Home Address: _____
Mailing Address: _____
Previous Address (if less than 3 years): _____
Home phone: _____ Cell/Work phone: _____ E-Mail: _____
Relation to patient: _____ Social Security #: _____
Employer: _____ Occupation: _____ No. Years employed: _____
Employer's address and phone number: _____
Spouses Name: _____Occupation: _____ Relation to patient: _____

INSURANCE INFORMATION

Full Name of Insured: _____ Relation to Patient: _____ Birth Date: _____
Mailing Address: _____
Home phone: _____ Cell/Work phone: _____ E-Mail: _____
Insurance Company: _____ ID #: _____ Group # _____
Insurance Co. Address and Phone number: _____
_____

EMERGENCY

Name of nearest relative not living with you: _____
Phone Number:_____
City, State and Zip: _____

DENTAL/MEDICAL HISTORY

Dentist's Name: _____ Phone: _____ Date of last cleaning? _____
Physician's Name: _____ Phone: _____ Date of last visit? _____
Has an orthodontist previously been consulted? _____ If so, when? _____
What concerns would you like Orthodontics to accomplish? _____

Is the patient currently under a physician's care?	____ No	____ Yes
If yes, for what reason? _____		
Have the tonsils and adenoids been removed?	____ No	____ Yes
Has the patient ever sucked a thumb or finger?	____ No	____ Yes
Until what age? _____		
Is the patient currently taking any drugs/medications?	____ No	____ Yes
If yes please list: _____		
Does the patient have any allergies?	____ No	____ Yes
If yes please list: _____		
Has there ever been an adverse reaction to latex or nickel?	____ No	____ Yes
Does the patient need antibiotics before seeing the dentist?	____ No	____ Yes

Please circle any of the following conditions that the patient has had or now has:

Congenital Heart Lesions	Anemia	Epilepsy/Seizures	Jaw/Facial Injuries
Heart Murmur	HIV/AIDS	Fainting Spells	Dental/Tooth Injuries
Rheumatic Fever	Hepatitis	Asthma	Frequent Headaches
Tuberculosis	Kidney Problems	Mouth Breathing	Clenching/grinding of Teeth
Persistent Cough	Liver Problems	Speech Problems	Ringing in the Ears
Abnormal Bleeding	Stomach Ulcers	Canker Sores	Sinus Trouble
High/Low Blood Pressure	Mental Disorders	Sore Facial Muscles	Smoke/Chew Tobacco
Diabetes	Arthritis	Jaw Locking	Pregnant Now?
ADD/ADHD	Sleep Apnea	Jaw Clicking/Popping	

Do you have any medical or dental problems not listed above? ____ Yes ____ No
Please explain_____

AFFIRMATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status.

I hereby give Dr. Cheron and Team permission to confirm appointments using the e-mail(s) I have provided.

_____ _____
Signature Patient/Parent/Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the Patient/Parent/Guardian.

_____ _____
Doctor Signature Date