Chang
ORTHODONTICS
Michael Chang DDS, MS

Welcome

We would like to welcome you to our office. In an effort to provide you the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Date______________

Name:____ Nickname ______________________

Address:____City:________________State:________Zip______________

Date of Birth:______________________ Email Address____

Phone (______)_________________ Work Phone (_____) _______________ Cell Phone (______)__________________

Social Security Number:______________________ Marital Status ______________________

Person to contact in case of emergency_________________________________ Phone_______________________

General Dentist____ Last Visited ______________________________

If Student, Name of School__________________________ _________ City_____________________________

Spouse or Parent's Name:____________________ Employer____________________ Work Phone_____________

How did you hear of us? _______________Please list any sports, hobbies, or musical instruments played _______________

What are your main concerns that you would like orthodontics to accomplish? _____________________________________

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:____ DOB ___________ SSN#______________________

Address:__________________________________City:_____________________ State:_________ Zip:___________

Phone: (____)__________________ Email: ______________________________ Work Phone (____)_____________

Employer____________________________ Occupation _____________________ Length of employment __________

Insurance Information

Name of Insured______________________________DOB______________Relationship to Patient _________________

SSN#:____________________ Name of Employer:______________________ Work Phone: (____)_________________

Address of Employer:______________________________City__________________State:_________Zip ______________

Insurance Company________________________ Grp #__________________ ID#____________________________

Ins Co Address:____ Ins Co. Phone:__________________________

------------ DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ---------------------------

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Name of Insured____________________________DOB______________Relationship to Patient ________________

SSN#:____________________ Name of Employer:____________________ Work Phone: (____)________________

Address of Employer:______________________________City_______________State:_________Zip ____________

Insurance Company_________________________ Grp #____________________ ID#_________________________

Ins Co Address:____ Ins Co. Phone:_______________________

Medical History

Physician name ______________________________ Phone ___________________ City ________________________

Date of last physical ___________ Medications currently being taken _____________________________________

Yes	No	Ever been hospitalized
Yes	No	Rheumatic Fever
Yes	No	Tuberculosis
Yes	No	Liver disease
Yes	No	Kidney disease
Yes	No	Heart attack/stroke
Yes	No	Congenital heart defect
Yes	No	Heart murmur
Yes	No	Hemophilia
Yes	No	High blood pressure
Yes	No	Anemia
Yes	No	HIV/AIDS
Yes	No	Hepatitis
Yes	No	Tonsils/adenoids removed

Yes	No	Cancer
Yes	No	Received radiation treatment
Yes	No	Growth problems
Yes	No	Endocrine problems
Yes	No	Latex allergy
Yes	No	Treated for emotional problems
Yes	No	Bone disorders/Bone loss
Yes	No	Diabetes
Yes	No	Seizures
Yes	No	Asthma
Yes	No	Are you pregnant?
Yes	No	Need medicine before dental work?

Please explain any "yes" answers________________

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Patients under 18

Yes	No	Has patient begun puberty?
Yes	No	If patient is a girl, has menstruation begun?
Yes	No	If patient is a boy, has their voice changed or have facial hair?

Dental History

Dentist name ______________________________ Phone ___________________ City __________________________

Date of last exam ___________ Do you have another appointment? _____________ If so, for what ___________

Yes	No	Speech problems/therapy
Yes	No	Clenching or grinding teeth
Yes	No	Brush/floss teeth daily
Yes	No	Fluoride treatment
Yes	No	Injury/pain in jaw, teeth, or mouth

Yes	No	Mouth breathing
Yes	No	Snoring during sleep
Yes	No	Missing or extra permanent teeth
Yes	No	Thumb sucking
Yes	No	Apprehensive about dental care

I have read and understood the "Notice of Privacy Practices" form that was provided by this office. This form is also known as the Health Insurance Portability and Accountability Act (HIPAA). I have had an opportunity to ask questions and have received a copy, if so requested.

Signature ____________________________________ Date ___________________