CHAPMAN
ORTHODONTICS

JOSHUA A. CHAPMAN DDS, MSD
ORTHODONTIC ADULT PATIENT INFORMATION

PATIENT'S NAME: _____ **NICKNAME:** _____

DATE OF BIRTH: _____ **SEX AT BIRTH:** _____ **AGE:** __

ADDRESS: _____ **CITY/ST:** _____ **ZIP:** _____

HOME PHONE: _____ **E-MAIL:** _____

CELL PHONE: _____ **CELL PHONE CARRIER:** _____

EMPLOYER: _____ **OCCUPATION:** _____

MARITAL STATUS: _____ **Social Security Number:** __

Emergency Contact Name: _____

Emergency Contact Phone#: _____ **Relationship:** _____

General Dentist:_____**Date of last dental cleaning and exam:** _____

Referred By: _____

RESPONSIBLE PARTY: ___ **SELF** ___ **OTHER--Name:** _____

Address: _____ **Phone #:** _____

Dental Insurance: YES OR NO

Insurance Company: _____ **Subscriber Employer:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

Social Security Number: _____**Subscriber ID#:** _____

Subscriber Address: _____

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

_____

Other family members seen by us? _____

509 IN-39 Bypass
Martinsville, IN 46151
812.822.2489

3925 E Hagan Street, Suite 201
Bloomington, IN 47401
812.822.2489

1683 Dixie Highway
Mitchell, IN 47446
812.849.4175

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Have you ever had an injury to your face, mouth, teeth or chin?	**Yes**	**No**
Have you ever had a serious reaction or complication to a dental procedure?	**Yes**	**No**
Do you brush your teeth twice a day?	**Yes**	**No**
Do you floss your teeth daily?	**Yes**	**No**
Do you see your dentist twice a year for cleanings?	**Yes**	**No**
Do you smoke or use tobacco in any form?	**Yes**	**No**
FEMALES: Are you currently pregnant?	**Yes**	**No**
Are you currently under the care of a physician?	**Yes**	**No**
Have you ever taken oral or intravenous bisphosphonates (osteoporosis)?	**Yes**	**No**

Have you ever had any of the following medical problems?

Y	**N**	**Abnormal bleeding**	**Y**	**N**	**High/Low Blood Pressure**
Y	**N**	**ADHD, anxiety, depression**	**Y**	**N**	**HIV+/AIDS**
Y	**N**	**Anemia or blood disorder**	**Y**	**N**	**Hospitalized for any reason**
Y	**N**	**Artifical joints or valves**	**Y**	**N**	**Kidney problems**
Y	**N**	**Cancer/chemotherapy/radiation**	**Y**	**N**	**Liver Disease or Hepatitis**
Y	**N**	**Asthma, sinus problems, hay fever**	**Y**	**N**	**Endocrine or Thyroid problems**
Y	**N**	**Diabetes**	**Y**	**N**	**Sleep Apnea**
Y	**N**	**Difficulty breathing**	**Y**	**N**	**Osteoporosis**
Y	**N**	**Drug/Alcohol abuse**	**Y**	**N**	**Rheumatic/Scarlet Fever**
Y	**N**	**Emphysema**	**Y**	**N**	**Severe/Frequent Headaches**
Y	**N**	**Epilepsy/Seizures/Fainting**	**Y**	**N**	**Arthritis or joint problems**
Y	**N**	**Fever Blisters/Herpes**	**Y**	**N**	**Eating disorder (Anorexia, Bulimia)**
Y	**N**	**Vision or hearing problems**	**Y**	**N**	**Tonsils or Adenoids removed**
Y	**N**	**Heart attack or Stroke**	**Y**	**N**	**Tuberculosis (TB)**
Y	**N**	**Heart murmur or defect**	**Y**	**N**	**Stomach ulcers or acid reflux**
Y	**N**	**Heart surgery or pacemaker**	**Y**	**N**	**Venereal disease/STD**
Y	**N**	**Pneumonia or mononucleosis**	**Y**	**N**	**Other _____**

Are you allergic to any of the following?

Y	**N**	**Aspirin, Ibuprofen, Acetaminophen**	**Y**	**N**	**Local Anesthetics**
Y	**N**	**Penicillin or other antibiotics**	**Y**	**N**	**Metals (jewelry, clothing snaps)**
Y	**N**	**Codeine or other narcotics**	**Y**	**N**	**Plastics or Acrylics**
Y	**N**	**Foods (peanut, milk/lactose, etc)**	**Y**	**N**	**Latex (gloves, balloons)**
Y	**N**	**Seasonal (plant pollen) or Animals**	**Y**	**N**	**Other _____**

Do/Did you have any of the any of the following?

Y	**N**	**Clenching/Grinding Teeth**	**Y**	**N**	**Jaw Joint (TMJ) discomfort**
Y	**N**	**Lip Sucking/Biting**	**Y**	**N**	**Speech Problems/Therapy**
Y	**N**	**Mouth Breathing/Snoring**	**Y**	**N**	**Thumb/Finger Sucking**
Y	**N**	**Nail Biting**	**Y**	**N**	**Tongue Thrust/Biting**
Y	**N**	**Frequent Canker Sores**	**Y**	**N**	**Other _____**

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

_____ _____

Signature **Date**

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