CHAPMAN
ORTHODONTICS

JOSHUA A. CHAPMAN DDS, MSD

ORTHODONTIC CHILD 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:** _____

SCHOOL: _____ **GRADE:** _____

HOBBIES: _____ **Social Security Number:** _____

FATHER'S NAME: _____ **PHONE #:** _____ **DOB:** _____

MOTHER'S NAME: _____ **PHONE#:** _____ **DOB:** _____

PATIENT LIVES WITH: _____ **Referred By:** _____

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

RESPONSIBLE PARTY NAME: _____ **DOB:** _____

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
Has puberty begun?	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.

_____ _____

Responsible Party Signature **Date**

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