CHUN ORTHODONTICS

CREATING BEAUTIFUL CUSTOMIZED SMILES

WITH PERSONALIZED, EXPERT CARE

CONFIDENTIAL PATIENT INFORMATION:

NAME OF PATIENT (FIRST AND LAST) _____GENDER____

NICKNAME/PREFERS TO BE CALLED_____DOB_____AGE_____

ADDRESS_____

STREET CITY ZIP

PHONE _____ _____

PATIENT/PARENT CELL MOM CELL SPOUSE/ PARENT DAD/GRANDPARENT

_____ _____

HOME PHONE PATIENT CHILD CELL

EMAIL _____ _____

PATIENT/PARENT EMAIL SPOUSE/CHILD EMAIL

CHILD PATIENT'S SIBLINGS/AGE_____

CHILD PATIENT'S SCHOOL AND GRADE _____ GRADE_____

ANY FAMILY MEMBERS TREATED HERE?_____

DENTIST NAME _____PHONE _____

DATE OF LAST CLEANING/CHECK UP_____

MEDICAL DOCTOR'S NAME _____ PHONE_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS_____

PHONE _____RELATIONSHIP_____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION IF PATIENT IS <u>CHILD:</u>

WHO IS BRINGING CHILD TO APPOINTMENTS:_____MARITAL STATUS_____

ALL PATIENTS PLEASE FILL OUT BELOW:

RESPONSIBLE PARTY RESIDENCE _____ OWN _____ RENT _____

_____

MAILING ADDRESS IF DIFFERENT FROM RESIDENCE_____

HOW LONG AT THIS ADDRESSS_____

PHONE _____ _____ _____

CELL HOME WORK

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) _____

SOCIAL SECURITY # _____ BIRTHDATE_____

RELATIONSHIP TO PATIENT: SELF _____ PARENT/STEP_____ SPOUSE_____

EMPLOYER_____ OCCUPATION _____

NUMBER OF YEARS EMPLOYED_____

SPOUSE'S NAME (FIRST AND LAST) _____

RELATIONSHIP TO PATIENT _____

EMPLOYER_____OCCUPATION_____

NUMBER OF YEARS EMPLOYED_____

PRIMARY INSURANCE INFORMATION

PRIMARY POLICY HOLDER NAME _____

SOCIAL SECURITY #_____ BIRTHDATE_____

EMPLOYER_____GROUP NUMBER_____

INSURANCE COMPANY_____PHONE #_____

INSURANCE ADDRESS_____ UNION LOCAL NO._____

_____

SECONDARY INSURANCE INFORMATION: Y N

SECONDARY POLICY HOLDER NAME _____

SOCIAL SECURITY # _____ BIRTHDATE_____

EMPLOYER_____GROUP NUMBER_____

INSURANCE COMPANY_____PHONE #_____

INSURANCE ADDRESS_____ UNION LOCAL NO._____

Y N I ALLOW THE OFFICE TO RUN A CREDIT CHECK, WHICH AIDS THE OFFICE IN PREPARING AN APPROPRIATE FINANCIAL CONTRACT FOR MY/MY CHILD'S TREATMENT.

CHUN ORTHODONTICS

HEALTH HISTORY

CREATING BEAUTIFUL CUSTOMIZED SMILES

WITH PERSONALIZED, EXPERT CARE

For the following questions, please mark yes (Y) or no (N). These answers are for office records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation.

Y N **LATEX** ALLERGY

Y N **METAL** ALLERGY

Y N ASPIRIN/IBUPROFEN

Y N PENICILLIN/OTHER ANTIBIOTICS

Y N OTHER SUBSTANCES

Y N TONSILS/ADENOIDS REMOVED- WHEN_____

Y N EAR/NOSE/THROAT CONDITIONS -EXPLAIN_____

Y N EXTRA TEETH

Y N CONGENITALLY MISSING TEETH OR ANY PERMANENT TEETH REMOVED

Y N EARLY LOSS OF BABY TEETH DUE TO DECAY OR TRAUMA_____

Y N TEETH SENSITIVE TO HOT/COLD

Y N TRAUMA INJURY TO PERMANENT TEETH

Y N JAW FRARUES, CYSTS, OR MOUTH INFECTIONS

Y N PERIODONTAL OR GUM PROBLEMS-ARE YOU BEING TREATED

Y N THUMB/FINGER SUCKING HABIT- DID IT STOP/WHEN _____

Y N TONGUE THRUSTING

Y N SPEECH PROBLEMS/SPEECH THERAPY

Y NMOUTH BREATHING HABIT

Y N TEETH GRINDING/JAW CLENCHING/CLICKING LOCKING OF TMJ

Y N PAIN IN JAW/FACE, RINGING IN EARS, HEADACHES_____

Y N FREQUENT CANKER SORES/COLD SORES

Y N SMOKE/CHEW TOBACCO

Y N HAVE OR HAD SUBSTANCE ABUSE_____

Y N ANY OPERATIONS/HOSPITALIZATION_____

Y N LEARNING DISABILITIES

Y N ADD OR ADHD

Y N BIRTH DEFECTS/HEREDITARY PROBLEMS _____

Y N ARE YOU ADOPTED

Y N THEUMATOID OR ARTHRITIC PROBLEMS

Y N ENDOCRINE OR THRYOID PROBLEMS

Y N DIABETES

Y N CANCER, TUMOR, RADIATION TREATMENT, OR CHEMOTHERAPY

Y N ACID REFLUX

Y N TUBERCULOSIS, POLIO, MONONUCLEOSIS, PNEUMONIA

Y N HIV/AIDS

Y N HEPATITIS, JAUNDICE, LIVER PROBLEMS

Y N SEIZURES, EPILEPSY, FAINTING SPELLS, OR NEUROLOGICAL PROBLEMS

Y N MENTAL HEALTH DISTURBANCE OR DEPRESSION

Y N VISION, HEARING, TASTE DIFFICULTIES

Y N HISTORY OF EATING DISORDER, ANOREXIA, BULIMIA

Y N EXCESSIVE BLEEDING OR BRUISING TENDENCY, ANEMIA OR BLEEDING DISORDER

Y N HIGH OR LOW BLOOD PRESSURE

Y N CARDIOVASCULARA PROBLEMS, SHORTNESS OF BREATH, ANGINA, HEART ATTACK

Y N HEART MURMUR, RHEUMATIC FEVER, HEART DEFECTS, ARTIFICIAL VALVES

Y N OSTEOPOROSIS/SCOLIOSIS

LIST ANY MEDICATIONS, NUTRIENT SUPPLEMENTS, HERBAL MEDICATIONS, NON-PRESCRIPTION MED_____

_____

GIRLS ONLY

Y N HAS MENSTRUATION BEGUN/WHEN _____

Y N IS PATIENT PREGNANT WHEN _____

BOYS ONLY

Y N VOICE CHANGE

I have read and understand the above questions. I will not hold Martha A. Chun DMD, MSD responsible for any errors or omissions I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

_____date _____

Patient or if minor-Parent/guardian