ChapmanSmiles
Shaping smiles for success.

PATIENT INFORMATION

Date: _____

Patient Name (Last, First, Middle) _____

Birth Date _____ Gender _____ School (if applicable) _____

Nickname_____ Hobbies _____

Address _____

City/Zip _____

Patient Home #_____ Patient Cell # _____

Whom may we thank for referring you to our office? _____

Any family members treated in our office? _____

Patient Email _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____

Residence Address _____ City/Zip _____

Mailing Address _____ City/Zip _____

Home # _____ Work # _____ Cell # _____

Employer _____ Occupation _____

Social Security # _____ Birth Date_____ Relationship to patient _____

Responsible Party Email: _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____

Social Security # _____ Birth Date _____ Work # _____

FAMILY INFORMATION (If Patient is a Minor)

With whom does the patient live (custodial parent)? _____

Are the patient's parents separated? yes no Divorced? yes no Remarried? yes no

Patient's Siblings (Names & Birth Dates) _____

INSURANCE INFORMATION

If you have HMO coverage, do you need a referral approved before starting? Y N

Subscriber's Name _____ Birth Date _____

Subscriber's SSN or ID # _____

Insurance Company Name _____

Phone # _____

Insurance Company Address _____

Do you have dual coverage? yes no

MEDICAL HISTORY

Patient Name _____

Physician Name _____ Date Last Seen _____
Patient's Height _____ Weight _____

Y N Has the patient been under the care of a physician during the last two years?
If yes, for what conditions? _____
Y N Does the patient have a current medical problem? _____
Y N Is the patient currently taking or using any pills, medications, or drugs? If yes, please list.
_____
Y N Has the patient had an unusual reaction to any medication? _____
Y N Has the patient ever had an injury to the head, face or mouth? _____
Y N Has the patient ever had a serious illness? _____
Y N Has the patient ever had surgery or been hospitalized? _____
Y N Has the patient ever had the tonsils or adenoids removed? At what age? _____
Y N Is the patient or could the patient possibly be pregnant? _____
Y N Do you anticipate the patient needing a MRI in the near future?_____When _____
Y N Does the patient have any congenital (born with) problems? _____
Y N Has the patient ever been diagnosed with a heart murmur? _____
Y N Has a doctor/dentist recommended that the patient take antibiotics prior to dental work?
Y N Is the patient allergic to anything (foods, medications, etc.)? If yes, please list.
_____

Has the patient ever been diagnosed or treated for any of the following (circle all that apply):

Arthritis	Emotional problem	AIDS or HIV	Heart condition
Anemia	Learning disability	Rheumatic fever	Kidney problem
Asthma	Speech Therapy	Tuberculosis	Liver problem
Breathing trouble	Bone disease	Ulcers	Nervous disorder
ADHD/ADD	Diabetes	Cancer	Growth disorder
Snoring	Fainting/Dizziness	Joint replacement	Allergies:_____
Pneumonia	Endocrine problem	Prolonged bleeding	_____
Sleep Apnea	Epilepsy	Bleeding disorder	Low/High blood pressure
Bed Wetting	Hepatitis	Recurrent pain	Communication disability

DENTAL HISTORY
Patient's Dentist _____ Date of Last Cleaning_____

Y N Is the patient currently undergoing any dental treatment? _____
Y N Does the patient ever have temperature sensitive teeth or bleeding gums?
Y N Has the patient had any teeth extracted? Why? _____
Y N Has the patient ever injured or broken any teeth? _____
Y N Does the patient have any missing or extra teeth? _____
Y N Does the patient have any difficulty eating, speaking or swallowing? _____
Y N Does the patient have any habits such as thumb sucking or nail biting? _____
Y N Does the patient have any dental or facial pain? _____
Y N Does the patient's jaw joints make noise or hurt? _____
Y N Has the patient's jaw ever locked open or closed? _____
Y N Does the patient habitually grind or clench the teeth together? _____
Y N Does patient snore?_____
Y N Is the patient aware of any swelling or growths in the mouth or face? _____
Y N Is there any other medical or dental information we should know? _____
_____

Signature (Parent or guardian if patient is a minor) _____ Date _____