



BOTHELL
ORTHODONTICS

JEREMY CHAISON, DDS, MSD
EMBRACE YOUR SMILE

WELCOME

SO THAT WE MIGHT BECOME BETTER ACQUAINTED,
PLEASE COMPLETE THE FOLLOWING.



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ORTHODONTICS

JEREMY CHAISON, DDS, MSD
EMBRACE YOUR SMILE

Patient Information

Date _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Birthdate _____ Social Security _____ - _____ - _____

Home Phone _____ - _____ - _____ Cell _____ - _____ - _____ Work Phone _____ - _____ - _____ OK to contact? Yes No

E-mail Address _____ Other family members in our practice _____

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

Responsible Party Information

Name _____
LAST FIRST MIDDLE MARITAL STATUS

Address _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address? _____ Own Rent

Previous Address _____
(IF LESS THAN 3 YEARS) STREET CITY STATE ZIP

Social Security # _____ - _____ - _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
LAST FIRST MIDDLE

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ - _____ - _____ Birthdate _____ Relationship to Patient _____

Insurance Information

A
Subscriber's Name _____ Subscriber's ID # _____

Insurance Company _____ Insurance Phone # _____

Group or Local # _____ Subscriber's Employer _____ Subscriber's Birthdate _____

B (if you have dual coverage)

Subscriber's Name _____ Subscriber's ID # _____

Insurance Company _____ Insurance Phone # _____

Group or Local # _____ Subscriber's Employer _____ Subscriber's Birthdate _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____ Phone _____ - _____ - _____

Medical History

Physician _____ City _____ Phone _____ - _____ - _____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE BEEN TREATED FOR OR MAY BE AT RISK FOR:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Behavior Problems |
| <input type="checkbox"/> Heart Disease or Murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Slow in Learning |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Eye or Ear Problems | <input type="checkbox"/> Kidney Disease | | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Grinding | | |
- Have you ever had an allergic reaction to any drug or medication? _____
- Have you ever taken bisphosphonates for osteoporosis? _____

Dental History

Dentist _____ City _____ Phone _____ - _____ - _____

Approximate date of last dental visit _____ Reason _____

CHECK ANY OF THE FOLLOWING THAT APPLY AND EXPLAIN BELOW:

- | | |
|---|--|
| <input type="checkbox"/> Any injury to the face, mouth, or teeth? | <input type="checkbox"/> Awareness of any gum or bone problems around teeth? |
| <input type="checkbox"/> Have you ever sucked your thumb or fingers? If so, until what age? _____ | <input type="checkbox"/> Inability to open mouth wide or move jaw normally? |
| <input type="checkbox"/> Do you grind or clench your teeth during the day or night? | <input type="checkbox"/> Prior orthodontic work or consultation with an orthodontist? |
| <input type="checkbox"/> Do you have any speech difficulty? | <input type="checkbox"/> Concerned about the appearance of your teeth? |
| <input type="checkbox"/> Do you have any difficulty chewing? | <input type="checkbox"/> Are you concerned about the appearance of your face and/or jaw structure? |
| <input type="checkbox"/> Teeth difficult to clean? | |
| <input type="checkbox"/> Pain or noise from jaw joint? | |

Comments:

What is your primary reason for seeking an orthodontic examination?

Has an orthodontist been consulted previously? If so, why are you seeking a second opinion?

I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes. This office reserves the right to verify the credit status of potential patient and/or responsible financial parties prior to extending credit for treatment fees.

Signature _____ Relationship to Patient _____

Updates (date and initial) _____