ADULT
PATIENT INFORMATION

Louis G. Chmura, D.D.S., M.S.
Orthodontics Exclusively
Marshall, Michigan 49068
(269) 781-4000
Fax: (269) 781-2850

Welcome to our Office!

We are a team committed to excellence and it is our privilege to help you with your smile. This information is held confidential and will help us to better serve you. Please answer both sides of this form completely.

Getting to know you

Name:	Nickname:	Birthdate:
Home Address:	City:	Zip:
Home Phone: ( )	SS#:	Sex:

What are your goals?

If you could change anything about your smile or bite, what would it be? ______

How long have you wanted to have this change? ______

What factors have been standing in your way? ______

Do you have any other concerns about undergoing orthodontic treatment? ______

Have any other family members had orthodontic treatment? (Please List) ______

Whom may we thank for referring you? ______

Medical History

Are you currently seeing a physician or taking any medications? Yes No If yes what for? ______

Are you pregnant? Yes No

Are you allergic to any medications? (Sulfa, Penicillin, Novocaine, Other?) Yes No If yes to what? ______

Do you suffer from frequent headaches? Yes No If yes when? ______

Describe any injuries to your face or teeth. ______

Have you had or do you currently have any history of:

Joint Swelling	Y	N	Heart Trouble	Y	N	Asthma	Y	N	Tuberculosis	Y	N
Artificial Joints	Y	N	Allergies to metal	Y	N	Psychiatric Treatment	Y	N	Rheumatic Fever	Y	N
Kidney Ailment	Y	N	Liver Ailment	Y	N	Epilepsy	Y	N	Heart Murmur	Y	N
Herpes/oral cold sores	Y	N	Blood Disorder	Y	N	Speech Problems	Y	N	Cancer	Y	N
Fainting/Seizures	Y	N	Arthritis	Y	N	Bone Disorder	Y	N			
Emotional Problems	Y	N	AIDS/HIV	Y	N	Hepatitis	Y	N			

Are there any medical, dental or surgical problems not covered above? ______

Physician: ______ City: ______ Phone: ______ Last Exam Date: ______

Dental History

How often do you brush your teeth each day? ❑ Several times ❑ Twice ❑ Once ❑ Less than once

Any Habits? (check all that apply) ❑ Lip biting ❑ Nailbiting ❑ Thumbsucking ❑ Other ______

Have you ever experienced: ❑ Headaches ❑ Ear Aches ❑ Jaw Clicking/Popping ❑ Jaw Pain

Have you ever been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

If any teeth have been removed (extracted), which? ______

Have you ever been treated for: ❑ Bad Breath ❑ TMJ ❑ Periodontal Disease

When were last dental x-rays taken? ______

Has an Orthodontist been consulted previously? ❑ Yes ❑ No Whom/When? ______

If yes, what was it that caused you to seek a second opinion? ______

Dentist: ______ City: ______ Phone: ______ Last Exam: ______

Over Please

Confidential Responsible Party Information

Name ______________________________ Marital Status __________
Residence ______________________________ City ______________ State ____ Zip ______
Mailing Address ______________________________ City ______________ State ____ Zip ______
How long at this address ______ Phone #'s: Home ____________ Work ____________ Cell ____________
Previous Address *(if less than 3 years)* ______________________ City ______________ State ____ Zip ______
Social Security # ______________ Birthdate ____ / ____ / ____ Relationship to patient ____________
Employer ______________________________ Occupation ______________ # years employed ____
Spouse's Name ______________________________ Relationship to patient ____________
Employer ______________________________ Occupation ______________ # years employed ____
Social Security # ______________ Birthdate ____ / ____ / ____ Work phone ______________

Confidential Patient Information

Patient's Name ______________________________
Residence ______________________________ City ______________ State ____ Zip ______
Social Security # ______________ Birthdate ____ / ____ / ____ Home phone ______________
If patient is a minor, give guardian's name ______________________________
Whom may we thank for referring you to our office? ______________________________

Insurance Information

Policy Holder's Name ______________________________ Social Security # ______________
Insurance Company ______________________ Group # ____________ Union Local # __________
Insurance Company's Address ______________________ Insurance Company's Phone ______________
Policy Holder's Employer ______________________________
Do you have dual coverage? ❑ YES ❑ NO If yes, complete the following information...
Policy Holder's name ______________________________ Social Security # ______________
Insurance Company ______________________ Group # ____________ Union Local # __________
Insurance Company's Address ______________________ Insurance Company's Phone ______________
Policy Holder's Employer ______________________________

Emergency Information

Name of nearest relative NOT living with you ______________________________
Complete Address ______________________ City ______________ State ____ Zip ______
Phone #'s: Home ______________ Work ______________ Cell ______________
Relationship to you ______________________________

Signature

I understand that where appropriate, credit bureau reports may be obtained.
Signature *(guardian's signature if patient is a minor)* ______________________________
Updates *(date and initial)* ______________________________

CONFIDENTIAL *(for record and pretreatment evaluation)*