CHAPMAN ORTHODONTICS

Peter L. Chapman, D.D.S., M.S.D.
www.drchapmanorthodontics.com
Orthodontics of Central Indiana, P.C.

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

☐ Male ☐ Female Referred by: _____ Age: _____

SSN: _____ Date of Birth: _____ Email: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Address: _____ City, State, Zip: _____

How long at current address? _____ Occupation/Position: _____

Employer's Name: _____ How long with present employer: _____
If child, name of school

PARENT INFORMATION - If patient is under the age of 18

Parents are: ☐ Married ☐ Divorced ☐ Separated Child lives with: _____

Father's Name: _____
Last First Middle

SSN: _____ Date of Birth: _____ Age: _____ Email: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Address: _____ City, State, Zip: _____

How long at current address? _____ Occupation/Position: _____

Employer's Name: _____ How long with present employer: _____

Mother's Name: _____
Last First Middle

SSN: _____ Date of Birth: _____ Age: _____ Email: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Address: _____ City, State, Zip: _____

How long at current address? _____ Occupation/Position: _____

Employer's Name: _____ How long with present employer: _____

Other Children: Name: _____ Age: _____ Name: _____ Age: _____

SPOUSE INFORMATION - For Adult Patients, if applicable

Spouse's Name: _____
Last First Middle

SSN: _____ Date of Birth: _____ Age: _____ Email: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

Employer's Name: _____ How long with present employer: _____

Occupation/Position: _____

DENTAL HISTORY

Dentist's Name: _____

Address: _____

_____

Phone: (_____) _____ Fax: (_____) _____

Date of Last Dental Exam: _____

Please check yes or no if patient has any history of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Face Injuries	☐	☐	Mouth Breathing	☐	☐	Root Canal Therapy	☐	☐	Jaw Joint Clicking
☐	☐	Teeth Injuries	☐	☐	Thumb/Finger Sucking	☐	☐	Crown/Bridges	☐	☐	Jaw Joint Pain
☐	☐	Cleft Lip/Palate	☐	☐	Tongue Thrusting	☐	☐	Artificial Teeth	☐	☐	Jaw Joint Locking
☐	☐	Missing Teeth	☐	☐	Speech Therapy	☐	☐	Other Tooth Removal	☐	☐	Clenching/Grinding
☐	☐	Extra Teeth	☐	☐	Gum Disease	☐	☐	Wisdom Tooth Removal			

Has any other family member had Orthodontic Treatment? ☐ No ☐ Yes ☐ Don't Know

Apprehensive about Orthodontic Treatment? ☐ No ☐ Yes ☐ Very

Full mouth X-rays or Panorex within last year? ☐ No ☐ Yes ☐ Don't Know

OTHER INFORMATION

Reasons for Seeking Orthodontic Treatment:

_____

What Questions Do You Most Want Answered?

_____

How would you like to receive reminders? ☐ Email ☐ Text Message

(*If text messaging is selected, please list your provider* _____.)

By completing the above information. I am authorizing Chapman Orthodontics to send e-mail and/or text messages based on information provided.

INSURANCE INFORMATION

Orthodontic Insurance: ☐ Yes ☐ No **Please provide us with a copy of your card.**

Insurance Company Name: _____ Subscriber Name: _____

Insurance Company Name: _____ Subscriber Name: _____

Other Insurance Information: _____

We understand, where appropriate, credit reports may be obtained.

Signature of Custodial Parent/Guardian/Patient	Relationship to Patient	Date
Signature of Custodial Parent/Guardian/Patient	Relationship to Patient	Date