FRIENDLY SMILES
• ORTHODONTICS •
MAN YEE CHAN, DMD

Patient Information

First Name:_____ Last Name:_____ Middle Initial:_____
Preferred Name:_____
Address:_____ City, State, Zip:_____
Date of Birth:_____ Soc. Sec:_____ Sex: ____Male ____Female
Home Phone:_____ Work Phone_____ Cell Phone_____
Employer/School_____ Status:____Full Time ___Part Time ___Retired ___Unemployed
How did you hear about our practice?_____

Responsible Party (only if someone other than the patient)

First Name:_____ LastName:_____ Middle Initial:_____
Preferred Name :_____
Address:_____ City, State, Zip:_____
Date of Birth:_____ Soc. Sec:_____ Sex: ____Male ____Female
Home Phone:_____ Work Phone_____ Cell Phone_____

Insurance Information

Name of Policy Holder:_____ Relationship to Patient:_____
Policy Holder Soc. Sec. #:_____ Policy Holder Date of Birth:_____
Employer:_____ Insurance Company:_____
ID #:_____ Group #:_____

Emergency Contact

Contact Person in Case of Emergency:_____
Phone #:_____ Relationship to Patient:_____

Medical History

Please answer the following questions:
Are you under a physician's care now?_____ If YES,_____
Physician:_____ Phone#:_____
Have you ever been hospitalized or had a major illness or condition?_____ If YES,_____
Have you ever had a serious head or neck injury?_____ If YES,_____
Are you taking any medications, pills or drugs?_____ If YES, (LIST ALL)_____
Are you allergic to Latex?_____ Any other allergies?_____ if YES,_____
Have you ever been treated for any of the following?

_____DHD/ADD	_____Autism	_____Asthma	_____Blood Disorder	_____Epilepsy/Seizures
_____Arthritis	_____Diabetes	_____Cancer	_____Heart Condition	_____Liver Problems
_____Hepatitis	_____HIV/AIDS	_____Tuberculosis		

Please list any current medical treatment including not mentioned above_____
Did menstruation start?_____ If YES, at what age?_____ Are you currently pregnant?_____

Dental History

General Dentist Name:_____Date of last cleaning?_____

Dentist Address:_____ Phone #:_____

Do you need pre-medication antibiotics before dental treatment? If YES, _____

Have the adenoids or tonsils been removed? If, YES,_____

Have you been informed of any missing or extra permanent teeth?_____

Any injuries to your face, mouth or chin?_____ If YES,_____

Any pain/tenderness in jaw joint?_____ If YES,_____

Do you play a musical instrument?_____ If YES,_____

Do you play any sports? _____ If YES, _____

Does/Did you have any of the following?

_____Unfavorable Dental Experience	_____Clenching or Grinding	_____Finger/Thumb Sucking
_____Prolonged Bottle/Pacifier	_____Mouth Breather	_____Speech Problems
_____Chewing/Eating Problems	_____Tongue Thrust	_____Teeth Sensitivity

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status.

Patient/Guardian Signature:_____ Date:_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA),
I have certain right to my privacy regarding my protected health information.
I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow up among the healthcare providers who may be involved in that treatment directly.

*Obtain payment from third party payers

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that a current, more complete description of the uses and disclosures of my health information is posted at the front desk and a copy is available upon my request. I understand that Friendly Smiles Orthodontics has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time to obtain a current copy of the Notice of Privacy Practices.

Parent/Guardian Signature:_____ Date:_____