



CENTRAL INDIANA ORTHODONTICS INC.

PETER L. CHAPMAN, D.D.S., M.S.D.

www.embrace.com

PATIENT INFORMATION

Patient's Name: Last First Middle
Male Female
Referred by:
Social Security Number: Date of Birth: Age:
Home Phone: Work Phone: Email:
Address: City, State, Zip:
How long at current address? Occupation/Position:
Employer's Name: How long with present employer:
If child, name of school

PATIENT INFORMATION - For Child Patients Only

If Child, Parents are: Married Divorced Separated Child lives with:
Father's Name: Last First Middle
Social Security Number: Date of Birth: Age:
Home Phone: Work Phone: Email:
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
Social Security Number: Date of Birth: Age:
Home Phone: Work Phone: Email:
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
Social Security Number: Date of Birth: Age:
Home Phone: Work Phone: Email:
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

- Face Injuries
- Teeth Injuries
- Cleft Lip/Palate
- Missing Teeth
- Extra Teeth

Yes No

- Mouth Breathing
- Thumb/Finger Sucking
- Tongue Thrusting
- Speech Therapy
- Gum Disease

Yes No

- Root Canal Therapy
- Crown/Bridges
- Artificial Teeth
- Other Tooth Removal
- Wisdom Tooth Removal

Yes No

- Jaw Joint Clicking
- Jaw Joint Pain
- Jaw Joint Locking
- Clenching/Grinding

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?

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/Parent

Relationship to Patient

Date

Signature of Custodial Parent/Guardian/Parent

Relationship to Patient

Date