Print Form

GARY W. CHU, D.D.S., M.S.

Specialist in Child, Adolescent and Adult Orthodontics

HEALTH QUESTIONNAIRE

PATIENT'S NAME	DATE OF LAST MEDICAL EXAMINATION	RESULTS

NAME OF PATIENT'S PHYSICIAN	ANY RECENT NOTICABLE CHANGES?

MEDICAL HISTORY

IS PATIENT UNDER PHYSICIAN'S CARE NOW ☐ YES ☐ NO

IS THERE ANY EXCESSIVE BLEEDING WHEN CUT ☐ YES ☐ NO

HAS PATIENT EVER BEEN HOSPITALIZED ☐ YES ☐ NO

HAVE TONSILS OR ADENOIDS BEEN REMOVED ☐ YES ☐ NO

IS PATIENT RECEIVING ANY MEDICATION ☐ YES ☐ NO

ARE THERE ANY EMOTIONAL PROBLEMS ☐ YES ☐ NO

HAS THE PATIENT EVER HAD SURGERY ☐ YES ☐ NO

WAS PATIENT ABSENT FROM SCHOOL/WORK FOR MORE THAN FIVE DAYS LAST YEAR DUE TO ILLNESS ☐ YES ☐ NO

HAS PATIENT EVER HAD AN UNUSUAL REACTION TO ANY DRUG SUCH AS PENICILLIN ☐ YES ☐ NO

LOCAL ANESTHETIC ☐ YES ☐ NO ANTIBIOTICS ☐ YES ☐ NO

HAS PATIENT EXPERIENCED FEVER, SWOLLEN GLANDS, WEIGHT LOSS, CHRONIC DIARRHEA AND MALAISE IN COMBINATION ☐ YES ☐ NO

HAS PATIENT EVER BEEN DIAGNOSED AS HAVING AIDS / HIV+ ☐ YES ☐ NO

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, PLEASE EXPLAIN _____

HAS THE PATIENT ANY HISTORY OF DIFFICULITY WITH ANY OF THE FOLLOWING: (CHECK)

☐ ALLERGIES, HAYFEVER	☐ DIABETES	☐ JAUNDICE	☐ THYROID
☐ ASTHMA	☐ DIGESTIVE PROBLEMS	☐ KIDNEY	☐ TMJ PAIN
☐ BACK PAIN	☐ EAR PAIN	☐ LIVER	☐ TUBERCULOSIS
☐ BLADDER	☐ EPILEPSY	☐ LUNG	☐ VENEREAL DISEASE
☐ BLOOD PRESSURE	☐ FAINTING	☐ MALIGNANCIES	☐ X-RAY THERAPY
☐ CEREBRAL PALSY	☐ HEARING	☐ MEASLES	☐ OTHER _____
☐ CHICKEN POX	☐ HEAD OR NECK PAIN	☐ MONONUCLEOSIS	_____
☐ CHRONIC SINUS	☐ HEART	☐ MUMPS	_____
☐ CONVULSIONS	☐ HEPATITIS	☐ RHEUMATIC FEVER	_____

DENTAL HISTORY

HOW MANY TIMES A YEAR HAS YOUR DENTIST EXAMINED PATIENT'S TEETH _____ APPROX. DATE LAST VISIT _____

HAS PATIENT EVER RECEIVED A SEVERE BLOW ON THE TEETH OR JAWS ☐ YES ☐ NO

IS PATIENT CONCERNED ABOUT APPEARANCE OF HIS/HER TEETH ☐ YES ☐ NO

HAS THE PATIENT EVER BEEN TEASED ABOUT THE APPEARANCE OF HIS/HER TEETH ☐ YES ☐ NO

DOES THE PATIENT PLAY A MUSICAL INSTRUMENT? ☐ YES ☐ NO IF SO, NAME _____

HAS ANY MEMBER OF YOUR FAMILY HAD ORTHODONTIC TREATMENT ☐ YES ☐ NO

ARE YOU AWARE THAT SOME APPOINTMENTS WILL INFRINGE UPON SCHOOL / WORK TIME. ☐ YES ☐ NO

DOES THE PATIENT HAVE ANY PROBLEMS WITH SORE GUMS ☐ YES ☐ NO

DOES THE PATIENT BRUSH HIS / HER TEETH IN THE MORNING, AFTER LUNCH, BEFORE RETIRING ☐ YES ☐ NO

DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS: FINGER / THUMB SUCKING ☐ YES ☐ NO NAIL-BITING ☐ YES ☐ NO

GRINDING TEETH AT NIGHT ☐ YES ☐ NO MOUTH BREATHING ☐ YES ☐ NO

HAS THE PATIENT EVER HAD SPEECH THERAPY ☐ YES ☐ NO

DOES THE PATIENT WANT HIS / HER TEETH STRAIGHTENED. ☐ YES ☐ NO

DO YOU DESIRE COMPLETE DENTAL SERVICE FOR THE PATIENT ☐ YES ☐ NO

WHO FIRST NOTICED THE NEED FOR ORTHODONTIC TREATMENT ☐ DENTIST ☐ PARENT ☐ PATIENT

WHAT SPORTS DO YOU PLAY _____

PLEASE MAKE ANY OTHER COMMENTS YOU FEEL MAY BE HELPFUL _____

CHIEF CONCERNS _____

HOW DOES THE PATIENT FEEL ABOUT BRACES _____

SIGNATURE _____ SIGNATURE OF DENTIST _____

DATE

UPDATED _____ _____

UPDATED _____ _____

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PATIENT HISTORY FORM

Interests		EXAM Date ____ Day ____ Time ____		Records Scheduled ☐ Yes ☐ No	X-rays in folder ☐ Yes ☐ No
Patient's Name	Social Security No.	Sex ☐ M ☐ F	Age Yrs Mos	Birth Date	
Address City		Zip	Adopted? ☐ No ☐	Home Phone	
School/Employer	Grade/Position		Height (Pt) Ft In	Weight Lbs	
Father or Husband	Date of Birth		Height (F) Ft In	Marital Status	
Address	City			Home Phone	
Employer	Department			Work Phone	
Mother or Wife	Date of Birth		Height (F) Ft In	Marital Status	
Address	City			Home Phone	
Employer	Department			Work Phone	
Referred By ☐ Dentist ☐ Other	Name & Address				
Siblings ☐ Yes ☐ No	Name (AGE) ____ ( )	____ ( )	____ ( )	____ ( )	____ ( )
Siblings in Tx/Treated ☐ Yes ☐ No	Stage of Tx				

DENTAL HISTORY

Pt. Had Ortho Tx In Past? ☐ Yes ☐ No	Orthodontist	City	State	Dentist
Parent Had Ortho. Tx? ☐ Yes ☐ No	☐ Father ☐ Mother			DR:
Dental Trauma? ☐ Yes ☐ No	Trauma			Date of Last Dental Visit

INSURANCE

Insurance Coverage ☐ Yes ☐ No	Relation to Patient	Ins. Address	Ins. Phone no.
Employer	Department		
Ins Name	Group No.	Plan No.	
Subscriber's Name	Social Security No.		
Secondary Ins. Coverage ☐ Yes ☐ No	Relation to Patient	Ins. Address	Ins. Phone no.
Employer	Department		
Ins Name	Group No.	Plan No.	
Subscriber's Name	Social Security No.		

FINANCIAL INFORMATION

Fees for professional services rendered are payable in full within 30 days unless a specific payment plan has been approved in advance of treatment. Payments made while you are in the office are always appreciated. A service charge of 1 1/3% per month will be made on all account balances which are over 60 days old. This is an annual rate of 13.56%.

In order to expedite the preparation, mailing and processing of any dental insurance, I hereby authorize Dr. Gary W. Chu DDS, MS to release any information and to receive payment of any group insurance benefits otherwise payable to me.

Date _____ Signed _____

EXAM OUTCOME		Date	Dr.	TC	M	F	Other
☐ Pre-Active Tx Accepted ☐ PET ☐ PAT ☐ OBS ☐ ____ mo. Recall	FEE $	☐ WCB for Pre-Tx	Reason				
☐ RECORDS Accepted _____	FEE $	☐ Records Rejected ☐ WCB for Records	Reason				
☐ Limited Active Tx Accepted	FEE $	☐ L/M Active Tx Rejected ☐ WCB for L/M Tx	Reason				

Exam Notes

APPOINTMENTS MADE

Diagnostic Records ____ @ ____

Treatment Conference ____ @ ____

Orientation (Separation) ____ @ ____

____ : ____ @ ____

____ : ____ @ ____

CHECK LIST

- ☐ Pt. History Completed
- ☐ Dictated Exam Completed
- ☐ Tx Indications Completed
- ☐ Fees/Fin. Arr. Explained
- ☐ Exam Fee Card Given
- ☐ Long/Short Appts. Reviewed
- ☐ P.C.D. (Code-04) Letter Sent
- ☐ Necessary Letters Requested
- ☐ Follow-up Required? ☐ Yes ☐ No
- ☐ Statistics Completed
- ☐ Insurance Forms Obtained
- ☐ Insurance Pre-Auth. Sent
- ☐ Film Shown
- ☐ Records Appointment Made
- ☐ Tx Conference Appt. Made
- ☐ Evaluation Control Dates Set
- ☐ Computer Exam Data Entered

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