CHIRA ORTHODONTICS
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CHIRA ORTHODONTICS
. . . more than beautiful smiles.

PATIENT INFORMATION:

Todays Date: _____
First Name:_____ MI:____ Last Name: _____
Date of Birth: _____ Sex: M F Height: _____ Weight: _____
Address: _____
City: _____ State: ____ Zip Code: _____
Primary Care Provider: _____ City: _____ State: _____
Dentist: _____ Last dental check up: _____
Hobbies: _____ Pets: _____
Siblings: Name: _____ Age:____ Sex: M F Name: _____ Age:___ Sex: M F
Name: _____ Age:____ Sex: M F Name: _____ Age:___ Sex: M F
Have they had orthodontic treatment? ☐YES ☐NO When?:_____
Adopted?: ☐YES ☐NO Patient resembles: ☐Neither Parent ☐Mother ☐Father
Mother's height: _____ Father's height: _____
Girls: Has she started menstruation?: ☐YES ☐NO When? _____
Boys: Has his voice changed?: ☐YES ☐NO When? _____
Has the patient had a history of thumb sucking or finger sucking?: ☐YES ☐NO Stopped? _____
Does the patient play any musical (wind) instruments? ☐YES ☐NO What? _____
Has anyone in your family had orthodontic work done in our office? _____
Who referred you? _____ How did you hear about our office? _____
Why are you seeking an orthodontic Consultation? What would you like us to do for you? _____
_____

Parents: ☐Married ☐Divorced ☐Other: _____
Parent/Guardian #1 Name: _____ Date of Birth: _____
Occupation: _____ Employed by: _____
Business Address: _____
Email: _____ Home Address (if different than patient's): _____
City: _____ State: _____ Zip code: _____ Phone Number: (____)_____
Parent/Guardian #2 Name: _____ Date of Birth: _____
Occupation: _____ Employed by: _____
Business Address: _____
Email: _____ Home Address (if different than patient's): _____
City: _____ State: _____ Zip code: _____ Phone Number: (____)_____
Who is financially responsible? (if other than parent) _____ Relationship to child: _____
Who has legal custody of child?_____

Chira Orthodontics is not affiliated with any dental or medical insurance provider. If you have orthodontic benefits, we will provide you with a claim form that you can submit to your dental insurance company. The insurance company will reimburse you if a benefit is due to you according to your policy. If you have an orthodontic benefit with a dental insurance company or any other provider, we strongly encourage you to become aware of your specific benefits by contacting your insurance carrier. Doing this will allow you to plan for costs and payments, as well as avoid any unwanted financial difficulties when you begin treatment.You as the patient or parent, are ultimately responsible for any fees incurred at our practice. We are happy to work with you to maximize your orthodontic benefit and can provide you with a statement of services rendered. Please be aware that most insurance companies do not cover the initial exam or diagnostic records, so payment of these services are your responsibility.

Is there any other information that may be helpful? _____
Signature of Patient (Parent or Guardian if minor): _____ Date: _____

HEALTH HISTORY RECORD:

Patient Name: _____ DATE:_____

Your health is important to us. In order to provide excellent care with safety, it is necessary to become acquainted with vital information related to each patient. Therefore, it is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask us for assistance.

Is the patient experiencing any health problems? YES NO If yes, explain: _____
Any major or unusual illnesses? YES NO If yes, explain: _____
Currently under physician's care? YES NO If yes, explain: _____
Any drug allergies or sensitivities? YES NO If yes, please list: _____
Do you have a latex allergy? YES NO Have you ever had a blood transfusion? YES NO
Have you had any serious illness? YES NO If yes, explain:_____
Women: Are you currently pregnant? YES NO If yes, how many months: _____
Women: Are you currently taking any birth control or hormone replacement therapy?_____
Currently taking medications, vitamins, supplements? Please list along with dosage:

Check the box if you currently have or had any of the following:

☐ Heart Trouble
☐ Heart Pacemaker
☐ Heart Murmur
☐ Bronchitis
☐ Tuberculosis
☐ Radiation Treatment
☐ AIDS
☐ Hives/Skin Rash
☐ Glaucoma
☐ Porphyrin
☐ Asthma
☐ Persistent Cough
☐ Diabetes
☐ Mitral Valve Prolapse
☐ Artificial Heart Valve
☐ Psychiatric Treatment
☐ Anemia
☐ Chemotherapy (Cancer)
☐ Jaundice
☐ Depression
☐ Arthritis
☐ Stroke
☐ Epilepsy
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ STI or STD
☐ Rheumatic Fever
☐ Hepatitis
☐ Lyme Disease
☐ Snoring ☐ Apnea
☐ Congenital Heart Disease
☐ Alcoholism
☐ Drug Disease
☐ Emphysema
☐ Ulcers
☐ Sinus Disease
☐ Allergies
☐ Development Delays
☐ Hip/Knee Replacement
☐ Connective Tissue Disorder

Do you smoke? YES NO If yes, how much:_____
Have you had any accidents involving your teeth: _____
Have you ever had an injury to your face, neck or jaws? YES NO If yes, where: _____
Mouth Breathing: while awake? _____ while asleep? _____
Do you suffer from frequent headaches, neck or back pain? YES NO If yes, where: _____
Do you have difficulty opening your mouth wide? YES NO
Does your jaw ever click or pop? YES NO If yes, how often:_____
Do you have pain in front of your ears? YES NO If yes, how often:_____
Do you have any pre-existing TMJ problems? _____
Have you ever had any difficulty with past dental treatment? YES NO If yes, explain:_____
_____

Check the box if currently have of had any of the following habits:

☐ Nail Biting ☐ Lip Biting ☐ Lisp/ Speech Issues ☐ Thumb Sucking ☐ Pencil Biting
☐ Mouth Breathing ☐ Grinding ☐ Clenching ☐ Other_____

The above medical history is accurate and current to the best of my knowledge. I understand I need to notify the office whenever there is a change in health history.

Signature of Patient (Parent or Guardian if minor)_____ Date:_____

PATIENT MOTIVATION FOR TREATMENT

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us understand your problem by checking the following information. Please be specific by checking the words: *more, less, forward, backward, longer, shorter, etc..*

THE TEETH

If your teeth could be changed, how would you like them to change?

- ☐ Straighten the front teeth: ☐ *Upper* ☐ *Lower*
- ☐ Straighten the back teeth: ☐ *Upper* ☐ *Lower*
- ☐ Make the upper front teeth: ☐ *Longer* ☐ *Shorter*
- ☐ Move upper teeth: ☐ *Forward* ☐ *Backward*
- ☐ Move lower teeth: ☐ *Forward* ☐ *Backward*
- ☐ Make the line of the upper front teeth more level
- ☐ Other: _____

THE FACE

If your facial appearance could be changed, how would you like them to change?

- ☐ Get rid of the sag under the lower jaw
- ☐ Move chin: ☐ *Forward* ☐ *Backward*
- ☐ Move chin ☐ *Left*/☐ *Right* to center it
- ☐ Move lower lip: ☐ *Forward* ☐ *Backward*
- ☐ Move upper lip: ☐ *Forward* ☐ *Backward*
- ☐ Move the area around the nose: ☐ *Forward* ☐ *Backward*
- ☐ Make the profile of my nose: ☐ *Longer* ☐ *Shorter*
- ☐ Move the area under my eyes: ☐ *Forward* ☐ *Backward*
- ☐ Make the cheekbones: ☐ *Larger* ☐ *Smaller*
- ☐ Show ☐ *More*/☐ *Less* of my ☐ *Teeth*/☐ *Gums* when I smile
- ☐ Make my lips ☐ *Closer together*/☐ *Farther apart* when my teeth are touching
- ☐ Make my lips not touch and roll out when my teeth are touching
- ☐ Reduce the strain in my ☐ *Chin*/☐ *Lips* when I close my lips
- ☐ Make my face more: ☐ *Narrow* ☐ *Wide*
- ☐ Reduce the ☐ *Width*/☐ *Fullness* of my lower jaw behind my mouth
- ☐ Other: _____

Symptoms

If you want to reduce pain or discomfort, where would it be located?

☐ In front of my ears:	☐ *Right* ☐ *Left* ☐ *Both Sides*
☐ Below my ears:	☐ *Right* ☐ *Left* ☐ *Both Sides*
☐ Above my ears:	☐ *Right* ☐ *Left* ☐ *Both Sides*
☐ In my ears:	☐ *Right* ☐ *Left* ☐ *Both Sides*
☐ Neck:	☐ *Right* ☐ *Left* ☐ *Both Sides*
☐ Shoulders:	☐ *Right* ☐ *Left* ☐ *Both Sides*
☐ Temples:	☐ *Right* ☐ *Left* ☐ *Both Sides*
☐ Eyes:	☐ *Right* ☐ *Left* ☐ *Both Sides*

- ☐ Teeth
- ☐ Sinuses
- ☐ Other _____

_____

_____

TMJ Questionnaire:

Patient Name: _____ DATE:_____

Please answer all questions:				
Do you have clicking, popping or grating noises in your:			☐Right Jaw Joint	☐Left Jaw Joint
When did you first become aware of this noise?				
Has the noise recently become more pronounced? If yes, when:				
Do you have pain in or around the:			☐Right Jaw Joint	☐Left Jaw Joint
When did you first become aware of the pain?				
Has the pain recently become more pronounced? If yes, when:				
Is the pain worse:	☐Mornings	☐Evenings	☐At Meals	☐Other
Is the pain:	☐Dull	☐Continuous	☐Stabbing	☐Intermittent
☐Throbbing		☐Other:		
Does the pain sometimes feel like it is in the ear?			☐Yes	☐No
Do you think this problem has affected your hearing?			☐Yes	☐No
Does your jaw problem interfere with normal activities?			☐Yes	☐No
Are you, or, have you taken medication for this problem?			☐Yes	☐No
Explain:				
Did anything occur that may be related to the onset of this problem? If yes, explain:				
Do you have difficulty chewing? ☐Yes		☐No	What is the cause:	☐Pain in Joint
☐Limited Opening	☐Pain in Tooth	☐Missing Teeth	☐Joint Sounds	☐Other: _____ _____
Has your mouth ever locked open and you were unable to close? Explain:				
Have you had problems opening wide? Explain:				
Please indicate in what order (1st, 2nd, 3rd…) you became aware of each problem:				
Pain _____	Noise _____	Limited Opening ____	Locking _____	Other _____
What symptoms are most concerning to you:				
Are you aware of clenching:		☐Yes ☐No	When do you notice it:	
Are you aware of grinding:		☐Yes ☐No	When do you notice it:	
Are you currently experiencing unusual stress in your life?			☐Yes	☐No
Do you feel nervous tension affects this problem?			☐Yes	☐No
Have you had problems with other joints?			☐Yes	☐No
Have you had x-rays taken for this problem? If yes, when and where:				
Have you received previous treatment for this problem? If yes, when and where:				

PEDIATRIC SLEEP QUESTIONNAIRE:

Patient Name: _____ DATE:_____

WHILE SLEEPING DOES YOUR CHILD:	YES	NO	UNSURE
Snore more than half the time?	☐	☐	☐
Always snore?	☐	☐	☐
Snore loudly?	☐	☐	☐
Have “heavy” or loud breathing	☐	☐	☐
Have trouble breathing or struggle to breathe?	☐	☐	☐
HAVE YOU EVER:			
Seen your child stop breathing during the night?	☐	☐	☐
DOES YOUR CHILD:			
Tend to breathe through the mouth during the day?	☐	☐	☐
Have a dry mouth on waking up in the morning?	☐	☐	☐
Occasionally wet the bed?	☐	☐	☐
Wake up feeling un-refreshed in the morning?	☐	☐	☐
Have a problem with sleepiness during the day?	☐	☐	☐
Has a teacher commented that your child appears sleepy during the day?	☐	☐	☐
Is it hard to wake your child up in the morning?	☐	☐	☐
Does your child wake up with headaches in the morning?	☐	☐	☐
Did your child stop growing at a normal rate at any time since birth?	☐	☐	☐
Is your child overweight?	☐	☐	☐
THIS CHILD OFTEN:			
Does not seem to listen when spoken to directly?	☐	☐	☐
Has difficulty organizing tasks?	☐	☐	☐
Is easily distracted by extraneous stimuli?	☐	☐	☐
Fidgets with hands or feet or squirms in seat	☐	☐	☐
Is “on the go” or often acts as if “driven by a motor”	☐	☐	☐
Interrupts or intrudes on others (i.e. “butts in”)	☐	☐	☐

Total Number of “Yes” responses: _____

If 8 or more statements are answered “Yes”, consider referring for sleep evaluation

TELL US ABOUT YOURSELF:

What would you like us to call you? _____

What grade are you in? _____ At which school? _____

What do you love most about school? _____

What do you want to be when you grow up? _____

Who are your brothers and sisters? _____

Do you like to read? _____ What is your favorite book? _____

Do you like to watch TV? _____ What is your favorite show? _____

Do you play sports? What is your favorite sport? _____

Do you play a musical instrument? _____

Tell us about your pets? _____

Tell us about your hobbies and the things that you like to do in your spare time! _____
_____
_____

Do you know anyone else who come to our office? _____
What is your favorite thing about yourself? _____

Thank you!
We hope you like it here as much as we're going to like you!

Patient Name: _____

APPOINTMENT POLICY:

Because we value your time, we'd like to again share with you our guidelines regarding our appointment scheduling process. We understand that our office is not the only stop on your list of important places to be in a day, and we'll do our best to honor your schedule. Our regular office hours are Monday - Thursday from 8:30am until 5:00pm. Summer Hours are Monday and Tuesday 8:30am until 4:30pm and Wednesday and Thursday 7:30am until 2:30pm from June until end of August.

We schedule long appointments, such as diagnostic records, appliance insertion and banding/bonding/ repairs, during the quieter morning and early afternoon hours. Unfortunately, some school and/or work must be missed for these appointments. We can provide you with a printed school or work excuse at each visit. Once you are in active orthodontic treatment, we can see you for adjustments during after-school hours, or toward the end of your workday.

Because we take measures to respect your time, we ask that you do the same for us and our other patients. Due to the nature of our practice, many appointments are more than an hour long, and if cancelled at the last minute are difficult to fill. Please give at least 48 hours notice if you need to reschedule an appointment, to allow us time to fill that space with another patient.We understand that last-minute illnesses or emergencies occur, and we respond in kind if you need to cancel an appointment.

We request at least 48 hours notice for cancelled appointments. If you miss an appointment or provide less than 48 hours notice, there will be a minimum broken appointment charge ranging from $50 to $125, depending on the length of the appointment.

Thank you for your understanding.

INSURANCE POLICY:

Chira Orthodontics is not affiliated with any dental or medical insurance provider. If you have orthodontic benefits, we will provide you with a claim form that you can submit to your dental insurance company. The insurance company will reimburse you if a benefit is due to you, according to your policy.

If you have an orthodontic benefit with a dental insurance company or any other provider, we strongly encourage you to become aware of your specific benefits by contacting your insurance carrier. Doing this will allow you to plan for costs and payments, as well as avoid any unwanted financial difficulties when you begin treatment.

You, as the patient or parent, are ultimately responsible for any fees incurred at our practice. We are happy to work with you to maximize your orthodontic benefit and can provide you with a statement of services rendered. Please be aware that most insurance companies do not cover the initial exam or diagnostic records, so payment of these services are your responsibility. We accept cash, check, Visa and MasterCard.

Signature of Patient (Parent or Guardian if minor)_____ Date:_____

INFECTIOUS DISEASE PROTECTION:

We at Chira Orthodontics want you, our patient, to know that all protective measures are being taken to provide you with a safe, healthy clinical environment. We follow both the Center for Disease Control and the American Dental Association recommendations for minimizing risks to you and ourselves.

In following these precautions, we always:

1. Wear masks, protective eyewear, proper clothing and non-latex gloves.

2. Wash our hands between each patient using anti-bacterial soap.

3. Dispose our gloves after one use.

4. Heat sterilize dental instruments and autoclave hand-pieces after each use.

5. Clean and disinfect all surfaces and equipment in the treatment room.

6. Use disposable products when possible to eliminate cross-infection.

7. Handle all disposable materials according to federal, state, and local laws.

The risk of contracting infectious diseases during dental procedures is extremely rare. Due to the measures we take at Chira Orthodontics, you can feel confident about being a patient here and trusting us with your family and friends.

If you have any questions after reading our infection control measures, please ask Dr. Chira or any staff member. We will be happy to explain all of our procedures and safeguards. When you visit our office, you should feel assured that your health is protected.

Sincerely,
Dr. Chira and Staff