



CHIRA ORTHODONTICS

Dara J. Chira, DMD
 1073 North Ave.
 Burlington, VT 05408
 802-652-1010

PATIENT INFORMATION:

Today's Date: _____
 First Name: _____ MI: _____ Last Name: _____
 Date of Birth: _____ Sex: M F Height: _____ Weight: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone (primary): (____) _____ Work: (____) _____ Email: _____
 Primary Care Provider: _____ City: _____ State: _____
 Dentist: _____ Last dental check up: _____
 Occupation: _____ Employer: _____
 Business Address: _____
 Partner/Spouse's First Name: _____ MI: _____ Last Name: _____
 Date of Birth: _____ Phone (primary): (____) _____ Work: (____) _____
 Email: _____
 Occupation: _____ Employer: _____
 Business Address: _____
 Has anyone in your family had orthodontic work done in our office? _____
 Have you had previous orthodontic treatment? YES NO
 If YES, with whom? _____ Are you satisfied with the result? YES NO
 Why are you seeking an orthodontic Consultation? What would you like us to do for you? _____

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.

PLEASE CHECK IF THERE IS A HISTORY OF:

- | | | |
|---|---|---|
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Muscular Soreness around Head and Neck | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Jaw Joint Popping | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Jaw Joint Clicking | <input type="checkbox"/> Ringing in the Ears (Tinnitus) | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Jaw Locking | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Limited Opening | <input type="checkbox"/> Jaw Joint Soreness | <input type="checkbox"/> Sleep Issues |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Choking/Swallowing Difficulties | <input type="checkbox"/> Excessive Daytime Drowsiness |

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:

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

- | | | | | |
|--|-------------------------------------|--------------------------------|--|--|
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Lip Biting | <input type="checkbox"/> Lisp/ | <input type="checkbox"/> Thumb Sucking | <input type="checkbox"/> Pencil Biting |
| <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Grinding | Speech Issues | <input type="checkbox"/> Clenching | <input type="checkbox"/> 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:		<input type="checkbox"/> Right Jaw Joint	<input type="checkbox"/> 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:		<input type="checkbox"/> Right Jaw Joint	<input type="checkbox"/> 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:	<input type="checkbox"/> Mornings	<input type="checkbox"/> Evenings	<input type="checkbox"/> At Meals
	<input type="checkbox"/> Other		
Is the pain:	<input type="checkbox"/> Dull	<input type="checkbox"/> Continuous	<input type="checkbox"/> Stabbing
	<input type="checkbox"/> Intermittent		
	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Other:	
Does the pain sometimes feel like it is in the ear?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you think this problem has affected your hearing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your jaw problem interfere with normal activities?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you, or, have you taken medication for this problem?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Explain:			
Did anything occur that may be related to the onset of this problem? If yes, explain:			
Do you have difficulty chewing? <input type="checkbox"/> Yes		<input type="checkbox"/> No	What is the cause: <input type="checkbox"/> Pain in Joint
<input type="checkbox"/> Limited Opening	<input type="checkbox"/> Pain in Tooth	<input type="checkbox"/> Missing Teeth	<input type="checkbox"/> Joint Sounds
		<input type="checkbox"/> 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:		<input type="checkbox"/> Yes <input type="checkbox"/> No	When do you notice it:
Are you aware of grinding:		<input type="checkbox"/> Yes <input type="checkbox"/> No	When do you notice it:
Are you currently experiencing unusual stress in your life?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel nervous tension affects this problem?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had problems with other joints?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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:			

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