

# WELCOME!

**Please bring this completed form to your first appointment**  
*....so we can get to know you!*

My name is \_\_\_\_\_

I have family members that come here for orthodontic care & their names are \_\_\_\_\_

I have a friend(s) that comes here for there orthodontic care and their name is \_\_\_\_\_

**Please let us know how you heard about our office**

*(Check **all** that apply and **fill in blanks** below)*

- Dentist \_\_\_\_\_ Did your Dentist refer you to anyone else? \_\_\_\_\_
- Friend \_\_\_\_\_
- Dental staff \_\_\_\_\_
- Web Search Engine (e.g. Google)     Invisalign Website     AAO / ABO Website
- Charity / Sponsorship \_\_\_\_\_     School Dental Health Education
- News / Magazine Article \_\_\_\_\_     Yellow Pages
- Chenin Change Oral Hygiene Reward Program (Chenin Tokens, t-shirt, waterbottles, etc.)
- Chenin Orthodontics Building or Sign     Other \_\_\_\_\_

Orthodontics  
Dentofacial Orthopedics  
Children & Adults

10730 South Eastern Avenue, Suite 100  
Henderson, Nevada 89052  
P 702.735.1010 . F 702.735.6823  
info@cheninortho.com  
www.cheninortho.com



Stephen T. Chenin, DDS  
David A. Chenin, DDS, MSD

**PATIENT INFORMATION**

*-Please bring this completed form to your appointment-*

Home Phone \_\_\_\_\_ Date \_\_\_\_\_  
Work / Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Age (yr, mo)

Preferred Name (Nick Name) \_\_\_\_\_ Male  Female  SS# \_\_\_\_\_

**Address**  
How long at address? \_\_\_\_ Yrs \_\_\_\_\_  
Street Suite/Apt City State ZIP

If patient is a minor, who is legal guardian \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street Suite/Apt City State ZIP

Mailing Address \_\_\_\_\_  
(If Different than residence) Street Suite/Apt City State ZIP

How long at this address? \_\_\_\_ Yrs  Rent or  Own

Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Previous Address** \_\_\_\_\_  
(If less than 3 years at current) Street Suite/Apt City State ZIP

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Time at Current Employment \_\_\_\_\_  
Years

Employer Address \_\_\_\_\_  
Street Suite/Apt City State ZIP

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years at Current Employment \_\_\_\_\_

**INSURANCE**

Dental Insurance Company Name \_\_\_\_\_ Policy/Group # \_\_\_\_\_ Telephone \_\_\_\_\_

Dental Insurance Held By \_\_\_\_\_ SS# \_\_\_\_\_  
(Whose name is on the insurance policy) Last First Middle If not given above

Insured's Employer \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

2<sup>nd</sup> Dental Insurance Company Name \_\_\_\_\_ Policy/Group # \_\_\_\_\_ Telephone \_\_\_\_\_

2<sup>nd</sup> Dental Insurance Held By \_\_\_\_\_ SS# \_\_\_\_\_  
(Whose name is on the insurance policy) Last First Middle If not given above

Insured's Employer \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

**IN CASE OF EMERGENCY** Please contact \_\_\_\_\_ Telephone \_\_\_\_\_  
(nearest relative not living with you) First Last

Complete Address \_\_\_\_\_  
Street Suite/Apt City State ZIP

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due to me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office. I understand that where appropriate, credit bureau reports may be obtained.

\_\_\_\_\_  
Signature of Responsible Party



### MEDICAL HISTORY

-Please Answer All Questions-

Patient's Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_ Patient in good health?  No  Yes  
 Patient's Height: \_\_\_\_\_ Patient's Expected Height: \_\_\_\_\_ Mother's Height \_\_\_\_\_ Father's Height \_\_\_\_\_

**Has the patient experienced any of the following:** For all yes answers please provide specifics below:  
 Headache Problems  No  Yes Specifics: \_\_\_\_\_  
 Sinus/Ear/Nose/Throat Problems  No  Yes Specifics: \_\_\_\_\_  
 Eye/Glaucoma/Dizziness Problems  No  Yes Specifics: \_\_\_\_\_  
 Muscle/Neural Problems  No  Yes Specifics: \_\_\_\_\_  
 Bone / Artificial Joint Problems  No  Yes Specifics: \_\_\_\_\_  
 Hormonal Problems  No  Yes Specifics: \_\_\_\_\_  
 Blood/Prolonged Bleeding Problems  No  Yes Specifics: \_\_\_\_\_  
 Epilepsy/Seizure/Fainting Problems  No  Yes Specifics: \_\_\_\_\_  
 Urinary/Liver/Stomach Problems  No  Yes Specifics: \_\_\_\_\_  
 Learning/Psychiatric Problems  No  Yes Specifics: \_\_\_\_\_  
 Head/Neck/Back Problems  No  Yes Specifics: \_\_\_\_\_

**Allergies**  Metal  Latex  Drugs (please list) \_\_\_\_\_  
 Plastics  Foods (please list) \_\_\_\_\_  
**Please check any that apply:**  Dental Anesthetics  Other (Please List) \_\_\_\_\_

Childhood Diseases	Heart Problems	Breathing Problems	Chronic Diseases
<input type="checkbox"/> Tonsils Removed	<input type="checkbox"/> Murmur <input type="checkbox"/> Poor Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Cancer
<input type="checkbox"/> Mumps / Measles	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Valve Problem	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Radiation
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Angina <input type="checkbox"/> Heart Failure/Attack	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Diabetes <input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Palpations <input type="checkbox"/> Coronary Disease	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> HIV/AIDS

List any medications now being taken: \_\_\_\_\_  
 Have you ever taken Fosamax, Acetenol, Boniva, Aredia, Zometa, bisphosphonates, or any other bone medications?  No  Yes  
 Children: Regarding puberty...If female, has menstruation started? If male, has voice changed?  No  Yes When \_\_\_\_\_  
 Female Adults Only: Are you currently pregnant?  No  Yes Birth Control?  No  Yes  
 Do you smoke, if so how much/day? \_\_\_\_\_  
 Any other health problems, surgeries, etc. ? \_\_\_\_\_

### DENTAL HISTORY

Family Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_ Yearly Checkups?  One  Two  Never  
 Jaw or Face Injury/Trauma  No  Yes →  Broken Jaw  Other (Explain) \_\_\_\_\_  
 Tooth Injury/Trauma  No  Yes →  Broken  Chipped  Lost \_\_\_\_\_  
 Oral Habits (eg pacifier, etc.)  No  Yes →  Thumb Sucking  Other: \_\_\_\_\_ Until Age \_\_\_\_\_  
 Mouth Problems  No  Yes →  Mouth Breathing  Tongue Thrust  Grinding/Clenching \_\_\_\_\_  
 Bleeding Gums  No  Yes →  After Brushing  After Flossing  All times \_\_\_\_\_  
 Ever Had Speech Therapy?  No  Yes → Advised By: \_\_\_\_\_ For: \_\_\_\_\_  
 Jaw Joint Pain  No  Yes → Explain: \_\_\_\_\_  
 Jaw Joint Popping/Clicking  No  Yes →  Both Sides  Right Side  Left Side \_\_\_\_\_  
 Other Dental Problems  No  Yes → Explain: \_\_\_\_\_

Have you been evaluated for orthodontic treatment before? \_\_\_\_\_ Have you had problems with previous dental work? \_\_\_\_\_  
 How do you feel about braces? \_\_\_\_\_  
 What are you most excited about changing in your smile? \_\_\_\_\_  
 Questions for Dr. Chenin? \_\_\_\_\_

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing information I have given on this form is correct and that I am obligated to inform Dr. Chenin immediately if any of this information changes in the future.

Patient Name: \_\_\_\_\_ Signature of Patient or Guardian if patient is a minor \_\_\_\_\_

Doctors Comments: \_\_\_\_\_ ← OFFICE USE ONLY → \_\_\_\_\_  
 All Forms  
 Dentist  
 Spelling  
 Address  
 Phone  
 Email  
 Signed-in & BlueNote sent to TC