Southern New Hampshire Orthodontics
MICHAEL H. CHOW, D.D.S.
Dr. Michael Chow, Dr. Denise Chow, Dr. Bridget Ko & Dr. John Diune

Patient Information:

Name _____ Male/Female ___ Email _____

Address _____ City _____ Zip _____

Date of Birth _____ Home Phone _____ Cell Phone _____

Primary Physician _____ Address _____ Phone _____

Person legally responsible for patient:

Name _____ SS# _____ Date of Birth _____

Address _____ City _____ Zip _____

Occupation _____ Employer _____ Phone _____

Today's Date _____

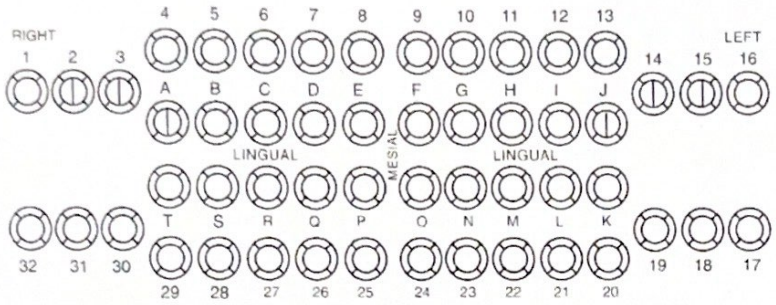
Chief Complaint _____

Referred by _____

Date of last dental exam _____

- for doctor use only -

EXAMINATION RECORD



EXAM / TREATMENT PLAN

OCS- OCS-

MEDICAL HISTORY	please CIRCLE		
CURRENTLY TREATED BY PRIMARY PHYSICIAN	Y	N	
TAKING MEDICINE NOW? If yes, please list	Y	N	meds dose/day
HEART DISEASE / HIGH BLOOD PRESSURE	Y	N	
RHEUMATIC FEVER	Y	N	
PROLONGED BLEEDING	Y	N	
ALLERGY TO PENICILLIN / OTHER ALLERGIES	Y	N	please list other allergies
CANCER / past hx CANCER / chemo or radiation therapy	Y	N	
ASTHMA	Y	N	
DIABETES	Y	N	
JAUNDICE	Y	N	
ANEMIA	Y	N	
FAINTING	Y	N	
CONVULSIONS / EPILEPSY	Y	N	
HIV POSITIVE (AIDS) / HEPATITIS / other infectious dz	Y	N	
AUTISM	Y	N	
ADHD	Y	N	

for doctor use only: **MED HX UPDATED** **DATE** **SIGNATURE**

DENTAL HISTORY

SOCIAL HISTORY [ ] TOBACCO [ ] ALCOHOL

FLUORIDE HISTORY

DIET HISTORY

PERIODONTAL HEALTH:

ORAL HYGIENE 1 2 3 4

CALCULUS MILD MODERATE SEVERE

OCCLUSION			
	MOLAR RELATIONSHIP		OJ (MM)
	TERMINAL PLANE		OB (O/O)
	CANINE (PRIMARY) REL		CROSSBITE
	ARCH SPACE (MM) U L		LIP
	MIDLINE		LIPLINE
	FACIAL SYMMETRY	PROFILE	HEIGHT
	HABITS	FRENUM	
	ORTHODONTIC DISPOSITION		
	TMJ	AIRWAY	
	3rd MOLARS 8 | 8 / 8 | 8	CONDLYES [ ] WNL	

SOFT TISSUES: INTRA-ORAL; EXTRA-ORAL

RADIOGRAPHIC FINDINGS

DATE

original REMARKS

AUTHORITY FOR TREATMENT

I hereby grant authority to Dr. Michael Chow, Dr. Denise Chow, and Dr. Bridget Ko for dental work for my child. Consent is hereby given for such treatment as Drs. Chow and Dr. Ko may consider necessary. I understand that I am financially responsible for any portion of the treatment not covered by the patient's insurance. I also affirm that the statements regarding the patient's health are correct to the best of my knowledge.

SIGNED ☆ _____ Date _____ Relationship _____
(Parent/Legal Guardian)

HIPAA Acknowledgement

I have read and understand this office's Notice of Privacy Practices.

☆ _____
(Parent/Legal Guardian Signature)

PHOTO CONSENT

Our office would like your permission to use photos on social media for office purposes only.

Please check below

____ I grant permission ____ I decline

☆ _____
Parent/Legal Guardian Signature

Please note: A service charge of 1.5% per month will be applied to account balances outstanding more than 30 days. (Minimum service charge is $1.50). Thank you.