Confidence with every smile

HANNAH ORTHODONTICS

CONFIDENTIAL PATIENT INFORMATION

Date_____ Phone (_____) _____

Patient: Last_____ First_____MI_____Nickname_____

Address_____City_____State_____Zip _____

Birthdate_____ Age_____Sex_____School/Employer _____

name/age name/age name/age

Siblings _____

Whom may we thank for referring you to our office? _____

Please include your email address for appointment reminders and to be able to access your account information online. _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Father/Spouse/Self: Last _____ First_____MI_____Nickname_____

Residence_____City_____State_____Zip _____

How long at this address?_____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Mailing address if different from residence_____City_____State_____Zip _____

Social Security # _____Relationship to Patient_____

Employer _____Occupation_____

# of years employed_____ DOB_____ Marital Status_____

Mother/Spouse/Self: Last_____ First_____MI_____Nickname_____

Address_____City_____State_____Zip _____

How long at this address?_____

Employer _____Occupation_____

# of years employed_____ DOB_____ Marital Status_____

Social Security # _____Relationship to Patient_____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address_____

Phone _____ Relationship_____

For those patients that will not be paying for treatment in full and will be setting up a payment plan, we will require our patient information sheet completed in its entirety and will be subject to a credit evaluation. In matters of divorce, the custodial parent is the responsible party, unless other arrangements are made.

DENTAL HISTORY

Dentist	Date of Last Visit
Address	Phone

What concerns you most about your teeth?

Please circle Yes or No (If Yes, please fill in details)

YES / NO	Are you presently in any dental discomfort?
YES / NO	Have you ever experienced any unfavorable reaction to dentistry?
YES / NO	Have you ever lost or chipped any teeth?
YES / NO	Is any part of your mouth sensitive to temperature or pressure?
YES / NO	Do your gums bleed when you brush?
YES / NO	Do you have any type of thumb or tongue habit? History of speech problems?
YES / NO	Have you ever been examined by an orthodontist?
YES / NO	Has anyone in the family received orthodontic treatment? How did they feel about the result?
YES / NO	Do you have any pain or soreness around your face, neck or back?
YES / NO	Are your teeth or jaws ever uncomfortable when you awaken in the morning?
YES / NO	Are you aware of your jaw clicking or popping?
YES / NO	Are you aware of clenching your teeth during the day?
YES / NO	Have you ever been told that you grind your teeth?
YES / NO	Do you have “tension” headaches?
YES / NO	Have you ever experienced ringing in your ears?

MEDICAL HISTORY

Physician

Address City State Zip Phone

YES / NO	Are you taking any medication?	Date of Last Visit
YES / NO	Are you allergic to any medication?	
YES / NO	Have you had any major operations?	
YES / NO	Have you ever been involved in a serious accident?	

(Circle any of the medical conditions below that you have had or currently have)

AIDS	Asthma or Hayfever	Eating Disorders	Bleeding Disorders	Seizures
Anemia	Diabetes	Heart Problems	Herpes	Tuberculosis
Arthritis	Dizziness	Hepatitis	High Blood Pressure	Tumor or Cancer
			ADD/ADHD	Learning Disability

Are there any medical conditions we have not discussed that you feel we should be made aware of?

Signature (Patient / Parent / Gaurdian)_____ Date_____