PATIENT FORM (ADULT)

Hamilton, Wilson & Hendrickson ORTHODONTICS

In an effort to provide the best service possible, we ask you to fill out this form as completely as possible!

PATIENT INFORMATION

Name _____ Sex ☐ M ☐ F ☐ OTHER
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

E-mail _____ Birthdate _____
MM/DD/YY

Marital Status _____

Home # _____ Work # _____ Cell # _____

Employer _____ Occupation _____

Dentist _____ Last Visited _____

How did you hear about our practice? ☐ ADVERTISEMENT ☐ FAMILY/FRIEND ☐ INTERNET ☐ DENTIST ☐ OTHER

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

Please list any other family members seen in our office: _____

Emergency Contact Information

Name _____
LAST FIRST MIDDLE

E-mail _____

Primary # _____

DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ Policy Owner's Address _____

Policy Owner's Birth Date _____ Relationship to Patient _____

Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Owner's Name _____

Policy Owner's Phone _____ Policy Owner's Address _____

Policy Owner's Birth Date _____ Relationship to Patient _____

Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

MEDICAL AND DENTAL HISTORY

Are you under the care of a physician? ☐ YES ☐ NO If yes, explain: _____

Physician _____ Phone _____ Last Visit _____

Are you pregnant? ☐ YES ☐ NO If so, how many weeks? _____

What are your main concerns that you would like orthodontics to accomplish?

_____

_____

Have you ever been evaluated for orthodontic treatment? ☐ YES ☐ NO If yes, explain: _____

Have your tonsils or adenoids been removed? ☐ YES ☐ NO Have you experienced jaw joint pain/discomfort (TMJ/TMD)? ☐ YES ☐ NO

Do you have any missing or extra permanent teeth? ☐ YES ☐ NO

Have you ever had injury to ☐ TEETH ☐ MOUTH ☐ CHIN If yes, explain: _____

Do you have speech problems? ☐ YES ☐ NO If yes, explain: _____

Do your gums bleed? ☐ YES ☐ NO Do you smoke or use electronic cigarettes? ☐ YES ☐ NO Do you like your smile? ☐ YES ☐ NO

Do you have any of the following habits?

☐ LIP SUCKING/BITING ☐ PROLONGED BOTTLE/PACIFIER ☐ MOUTH BREATHER ☐ THUMB/FINGER SUCKING
☐ NAIL BITING ☐ CLENCHING/GRINDING TEETH ☐ TONGUE THRUSTING ☐ CHEWING/EATING PROBLEM

Are you allergic to any of the following?

☐ METALS/PLASTICS ☐ DENTAL ANESTHETICS ☐ LATEX ☐ OTHER

MEDICAL AND DENTAL HISTORY CONTINUED

List all the drugs you are currently taking: This would include prescriptions, diet, or over-the-counter medications. Please include the dosage.

_____

_____

Have you ever taken any medications to strengthen your bones, such as a bisphosphonate? ☐ YES ☐ NO

Please describe any serious medical condition(s): This would include any allergies, serious illnesses, operations, hospitalizations, or surgeries.

_____

_____

Have you ever had any of the following?

- ☐ ADD/ADHD
- ☐ ABNORMAL BLEEDING
- ☐ ANEMIA
- ☐ ARTIFICIAL BONES/JOINTS/VALVES
- ☐ ASTHMA
- ☐ ARTHRITIS
- ☐ BACK PROBLEMS
- ☐ BLOOD DISEASE
- ☐ BLOOD TRANSFUSION
- ☐ CANCER/CHEMOTHERAPY
- ☐ CHEMICAL DEPENDENCY
- ☐ CIRCULATORY PROBLEMS
- ☐ CONGENITAL HEART DEFECT
- ☐ CORTISONE TREATMENTS
- ☐ PERSISTENT COUGH
- ☐ COUGHING BLOOD
- ☐ DIABETES
- ☐ DIFFICULTY BREATHING
- ☐ EPILEPSY/SEIZURES/FAINTING
- ☐ FEVER BLISTERS/HERPES
- ☐ GLAUCOMA
- ☐ HEART ATTACK/STROKE
- ☐ HEART MURMUR
- ☐ HEART SURGERY/PACEMAKER
- ☐ HEMOPHILIA
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV+/AIDS
- ☐ JAW PAIN
- ☐ KIDNEY PROBLEMS
- ☐ LIVER DISEASE
- ☐ MISTRAL VALVE PROLAPSE
- ☐ PSYCHIATRIC PROBLEMS
- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ RHEUMATISM
- ☐ SEVERE/FREQUENT HEADACHES
- ☐ SHORTNESS OF BREATH
- ☐ SICKLE CELL DISEASE/TRAITS
- ☐ SINUS PROBLEMS
- ☐ SKIN RASH
- ☐ SWELLING OF FEET OR ANKLES
- ☐ THYROID PROBLEMS
- ☐ TOBACCO HABIT
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ ULCERS/COLITIS
- ☐ VENEREAL DISEASE

SIGNATURE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Submitted by _____ **Date** _____