

NAME _____ AGE _____ NICKNAME _____ DATE _____

MEDICAL HISTORY

Patient's Physician: Dr. _____ Phone # _____

Has patient had his/her tonsils or adenoids removed? Yes No

Has patient ever had an unusual reaction to any drug? Yes No

Has patient had any of the following?

- | | | |
|----------------------|--------------------|---|
| [1] Arthritis | [6] Diabetes | [11] Major surgery |
| [2] Anemia | [7] Frequent colds | [12] Tuberculosis |
| [3] Bleeding problem | [8] Allergies | [13] Heart trouble |
| [4] Epilepsy | [9] Asthma | [14] Thyroid or Hormonal imbalance |
| [5] Nervous disorder | [10] Rheumatic | [15] Any other serious medical problems |

Does patient have a speech problem and if so, receiving speech therapy? Yes No

Is patient presently under the care of a physician or taking medication? Yes No

DENTAL HISTORY

PATIENT'S DENTIST: DR. _____ PHONE# _____

Does the patient presently suck his/her thumb or finger? please circle Yes No

Does the patient breathe mostly through the mouth? Yes No

Has the patient ever received a severe blow resulting in injury to the teeth or jaws? If yes please write in details _____ Yes No

Does the patient grind his/her teeth at night? Yes No

In the past, has the patient ever complained of clicking popping stiffness soreness in the jaw or the jaw muscles? please circle

Episodes when the jaw would not open or close normally? Yes No

Pain or discomfort in the front of the ear? Yes No

Headaches, neck or back pain? Yes No

If yes, please write date and details: _____

Has patient ever had orthodontic treatment or worn a retainer before? Yes No

Would patient object to wearing orthodontic appl. should they be indicated? Yes No

What is patients or parents primary concern _____

Comments _____

I certify that the information on this form is complete and true to the best of my knowledge.

I hereby authorize Dr. Dennis A. Hall to examine and in regards to the orthodontic needs of the patient request any necessary X-ray, growth data, study models or other diagnostic materials to proceed with this patients treatment with Dr. Hall.

I understand that there is no fee for the above services***, unless the diagnostic materials are taken or transfered out of the office.

***In the case of TMJ patiens, if you are referred to an outside lab for tomographic x-rays, there will be a charge from the lab.

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

Signature of patient / parent / responsible party

Patient Information

Date _____
Patient's Name _____
Address _____
Home Phone _____ Birthdate _____ Social Security # _____
If Patient is a minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Residence _____
Mailing Address _____
How long at this address _____ Home Phone _____
Previous Address (if less than 3 yrs) _____
Work Phone _____ Cell _____
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Address _____
Insured's Employer _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Telephone # _____
Do you have Dual coverage? Yes No If yes:
Insured's Name _____ Insured's Soc. Sec. # _____
Address _____
Insured's Employer _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Telephone # _____

Sibling names & ages _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship _____