NAME_____AGE _____NICKNAME_____DATE_____

MEDICAL HISTORY

Patient`s Physician: Dr._____Phone #_____

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

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

Has the 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 problem

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

Is the 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 fingers? 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: please circle

clicking popping stiffness soreness in the jaw or the jaw muscles?

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

What is the patient's or parent's 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 patient's 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.

Date_____

_____

Signature of patient / parent / responsible party

CONFIDENTIAL (for record and pretreated evaluation)

Patient Information

Date _____

Patient`s Name _____
Last First Middle

Address _____
Street City State Zip

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 _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____

E-mail _____

Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse`s Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured`s Name _____ Insured`s Soc. Sec. # _____

Address _____
Street City State Zip

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 _____
Street City State Zip

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 _____