

Patient Information

Date _____

Patient's name _____
Last First MiddleAddress _____
Street City Zip

Home Phone _____ Birth date _____ 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 MiddleResidence _____
Street City ZipMailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work phone _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birth date _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- 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.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth or 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? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
What is your attitude toward receiving orthodontic treatment? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake 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 chronic ringing in your ears? _____
- Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____
Female Patients only: _____
- Yes No Are you pregnant? _____
- Yes No Has menstruation started? _____

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Hughes to perform a complete orthodontic evaluation

Signature: _____ Date: _____

This office reserves the right to verify the credit status of potential patient and/ or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature: _____ Date: _____