Hi 5 ORTHODONTICS

WELCOME TO HI 5 ORTHODONTICS!

DATE: ______________ ____ MALE ___ FEMALE

PATIENT'S NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____
STREET CITY STATE ZIP

PHONE: (___) _____-____________ ___ CELL ___ HOME BIRTH DATE: ____/_____/____ SS#: ______________

IF PATIENT IS A MINOR, GIVE PARENT OR GUARDIAN'S NAME: ______________________________

RESPONSIBLE PARTY EMAIL: ______________________________ SCHOOL: ______________

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REQUIRED - RESPONSIBLE PARTY INFORMATION

NAME: ____
LAST FIRST MIDDLE MARTIAL STATUS

MAILING ADDRESS: ____
STREET CITY STATE ZIP

HOW LONG AT THIS ADDRESS? __________ PHONE: (___) ______- _____________ _____ CELL _____ HOME

SS #: __________________________ BIRTH DATE: ___________________ RELATIONSHIP TO PATIENT: ____________

EMPLOYER: ______________________________ OCCUPATION: _________________________ NO. YEARS EMPL: _______

?? ___ TEACHER ___ MILITARY ___ POLICE ___ FIRE ??

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SPOUSE'S NAME: ____
LAST FIRST MIDDLE

SPOUSE'S EMPLOYER: ______________________________ OCCUPATION: ______________________ NO. YEARS: ________

SPOUSE'S SS#: ____________________________ SPOUSE'S BIRTH DATE: _____________________

?? ___ TEACHER ___ MILITARY ___ POLICE ___ FIRE ??

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REQUIRED - INSURANCE INFORMATION

INSURED'S NAME: ________________________________ DOB: __________________ SS #: ____________________

INSURANCE CO: ____ GROUP #: _____________________

INSURANCE CO. ADDRESS: ____

INSURED'S EMPLOYER: ____

DO YOU HAVE DUAL COVERAGE? ___ YES ___ NO *IF YES, PLEASE CONTINUE,*

INSURED'S NAME: ________________________________ DOB: __________________ SS #: ____________________

INSURANCE CO: ____ GROUP #: _____________________

INSURANCE CO. ADDRESS: ____

INSURED'S EMPLOYER: ____

HI 5 ORTHODONTICS

IN YOUR OWN WORDS, WHAT IS THE PROBLEM?

____

HAVE YOU SEEN ANOTHER ORTHODONTIST? ________ WHO? ____________________ ANY TREATMENT? ____________

FAMILY MEMBERS TREATED HERE? ______________ WHO? __________________________ RELATIONSHIP: __________

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR STILL HAVE AT PRESENT:

- ☐ BABY TEETH REMOVED
- ☐ PERMANENT TEETH REMOVED
- ☐ TONGUE THRUST
- ☐ SPEECH PROBLEMS
- ☐ THUMB/FINGER SUCKING
- ☐ LIP BITING
- ☐ NAIL BITING
- ☐ TEETH CLENCHING
- ☐ TEETH GRINDING
- ☐ DIFFICULTY OPENING WIDE
- ☐ CLICKING OR POPPING JAWS
- ☐ PERIODONTAL CARE
- ☐ EARACHES
- ☐ FREQUENT HEADACHES
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART MURMUR
- ☐ ANEMIA/BLOOD DISORDER
- ☐ ASTHMA
- ☐ SINUS
- ☐ DIFFICULTY BREATHING THROUGH NOSE
- ☐ EPILEPSY OR SEIZURES
- ☐ FAINTING/DIZZY SPELLS
- ☐ TONSILS/ADENOIDS REMOVED
- ☐ ALLERGIES __________
- ☐ KIDNEY TROUBLE
- ☐ DRUG ADDICTION
- ☐ PROLONGED BLEEDING
- ☐ VENEREAL DISEASE
- ☐ HEPATITIS A, B, C
- ☐ AIDS/HIV
- ☐ CHEW TOBACCO
- ☐ SMOKE TOBACCO

ANY OTHER SERIOUS HEALTH DISORDER WE SHOULD KNOW ABOUT? ______________________________

ANY MEDICATIONS TAKEN REGULARLY? ______________________________

WHAT DO YOU EXPECT FROM ORTHODONTIC TREATMENT? ______________________________

CONCERNS? ______________________________

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING INFORMATION IS TRUE AND CORRECT. IF MY (OR MY CHILD'S) HEALTH CHANGES, OR MY MEDICATIONS CHANGE, I WILL INFORM THE OFFICE AS SOON AS POSSIBLE.

SIGNATURE (GUARDIAN IF PATIENT IS A MINOR): ______________________________ DATE: __________