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: ____/_____/____

PATIENT'S DENTIST: _____ DATE OF LAST VISIT: _____

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 ??

****

SPOUSE'S NAME: _____
LAST FIRST MIDDLE

SPOUSE'S EMPLOYER: _____ OCCUPATION: _____ NO. YEARS: _____

SPOUSE'S SS#: _____ SPOUSE'S BIRTH DATE: _____ PH: (____)_____

?? ___ 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 to patient: _____

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: _____