Hansen ORTHODONTICS

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Patient Registration Health History

Patient Name: _____ Date: _____

Nickname: _____ Birthdate: _____ Age: _____ Sex: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ School: _____

Hobbies: _____

Whom may we thank for referring you to our office? _____

Name of family members we have treated and relationship: _____

_____

Parents Divorced: Yes _____ No _____

Mother's Name: _____ Father's Name: _____

(Please complete other responsible party information on reverse side of this form)

Dental History

General Dentist: _____ Date of last visit: _____

Reason for Orthodontic Consultation: _____

Does the patient have to take antibiotics for dental treatment? ☐ YES ☐ NO

Explain: _____

What is your main concern regarding orthodontics? _____

_____

Do you feel patient will cooperate fully in orthodontic treatment? _____

Are you presently in dental pain? ☐ YES ☐ NO _____

Have you ever experienced 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? ☐ YES ☐ NO Where? _____

Is any part of your mouth sensitive to pressure? ☐ YES ☐ NO Where? _____

Do your gums bleed when you brush? ☐ YES ☐ NO _____

Do you have any type of thumb or tongue habit? ☐ YES ☐ NO _____ Age when stopped: _____

Are you a mouth breather? ☐ YES ☐ NO _____

Have you ever seen an Orthodontist? ☐ YES ☐ NOIf yes, who and when? _____

Has anyone in your family received 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 _____

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 the ears? ☐ YES ☐ NO _____

Do you have sleep apnea or do you snore? ☐ YES ☐ NO _____

Have you had your tonsils or adenoids removed? ☐ YES ☐ NO _____

If the patient is under age 16, height of parents:Mother: _____ Father: _____

Medical History

Physician: _____ Date of last visit: _____

Address: _____ Phone number: _____

Does the patient have to take antibiotics for dental treatment? ☐ YES ☐ NO

Please check Yes or No (If Yes, please fill in details)

Are you taking any medications? ☐ YES ☐ NO List medications: _____

_____

Are you allergic to any medication? ☐ YES ☐ NO _____

Do you have a history of a major illness? ☐ YES ☐ NO _____

Have you had any operations? ☐ YES ☐ NO _____

Have you ever been involved in a serious injury? ☐ YES ☐ NO _____

Have you seen a physician in the last 12 months? ☐ YES ☐ NO Why? _____

Circle any of the medical conditions below that you have had or currently have:

Abnonnal Bleeding/Hemophilia
ADD/ADHD Anemia Arthritis
Asthma/Hay Fever Autism Back & Neck Pain Bi Polar
Cold Sores/Fever Blisters
Congenilal Heart Defect
Diabetes Dizziness
Epilepsy Gastro Disorder
Heart Murmur High Blood Pressure
Hepatitis/Liver Problems
Herpes
HIV/Aids
Kidney Problems
Nervous Disorders
Osteoporosis
Heart Problems
Pneumonia
Prolonged Bleeding
Radiation/Chemotherapy
Rheumatic Fever
Thyroid Problems
Tuberculosis
Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

_____

Responsible Party Information

Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security No. _____ Birthdate: _____ Relationship to Patient _____

Employer: _____ Occupation: _____

(Spouse, Additional Responsible Party, or Other)

Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security No. _____ Birthdate: _____ Relationship to Patient _____

Employer: _____ Occupation: _____

Who will be responsible for payments? _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ Birthdate: _____

Social Security No. _____ Insurance Company: _____

Insurance Address: _____

Group No. _____ Subscriber ID No. _____

Insurance Phone Number: _____ Employer: _____

Do you have dual coverage? ☐ YES ☐ NO If Yes:

Insured's Name: _____ Birthdate: _____

Social Security No. _____ Insurance Company: _____

Insurance Address: _____

Group No. _____ Subscriber ID No. _____

Insurance Phone Number: _____ Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Home Phone: _____ Cell Phone: _____

Are you aware that some appointments will be during school/work hours? ☐ YES ☐ NO

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth. In the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body party and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I also give permission for this office to release or submit information to the insurance company where necessary. I understand that, where appropriate, credit bureau reports may be obtained.

Signature: _____ **Date:** _____