Member American Association of Orthodontists
My Life. My Smile. My Orthodontist.®

# Hall Orthodontics

DENISE A. HALL, DMD, MS

**The benefits to a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form completely. The better we communicate, the better we can care for you.**

## ALL ABOUT YOU

Today's Date: ____________________________________________

Name: ____________________________________________
LAST MIDDLE FIRST

Preferred name: ______________________ Male Female

Birthdate: ____/____/____ Age: ______ SS#: _______________

Home Address: ____________________________________________

____________________________________________

Single Married Divorced Separated Widowed

Hm#: ____________________ Cell#: ____________________

Wk#: ____________________ Ext.: ______ DL#: _____________

Employer: ____________________________________________

Employer's Address: ____________________________________

How long there? _______ Occupation: ______________________

Where and when are the best times to reach you: _______________

Whom may we thank for referring you? _____________________

Other family members seen by us: ________________________

____________________________________________

General Dentist: ________________________________________

Dentist's Address: ______________________________________

Last Visit Date: ________________________________________

Yes No Would you like us to email you appointment reminders?

Email: ____________________________________________

## ORTHODONTIC INSURANCE

### PRIMARY

Orthodontic Coverage? Yes No

Insurance Co. Name:

____________________________________________

Insurance Co. Address:

____________________________________________

Insurance Co. Phone: ____________________________________

Group #: ____________________________________________

Policy Owner's Name: _________________________________

Birth date: ____/____/____ Policy Owner's SS#: _______________

Relation: ____________________________________________

Policy Owner's Employer: _______________________________

### SECONDARY

Insurance Co. Name:

____________________________________________

Insurance Co. Address:

____________________________________________

Insurance Co. Phone: ____________________________________

Group #: ____________________________________________

Policy Owner's Name: _________________________________

Birth date: ____/____/____ Policy Owner's SS#: _______________

Relation: ____________________________________________

Policy Owner's Employer: _______________________________

## SPOUSE INFORMATION

His/Her Name: __________________________________________

Employer: ____________________________________________

Wk#: _______________ Ext.: _______ SS#: __________________

Birthdate: ____/____/____

Person responsible for account: __________________________

Wk#: _______________ Ext.: _______ SS#: __________________

Employer: ____________________________________________

Billing Address: ________________________________________

____________________________________________

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## MEDICAL HISTORY

For the following questions circle yes (Y), no (N), or don't know/understand (DK/U). The answers are for office records only and will be considered confidential. A through and complete history is vital to a proper orthodontic evaluation.

**Now or in the past, has the patient had:**

Y N DK/U Birth defects or hereditary problems?
Y N DK/U Bone fractures, any major accidents?
Y N DK/U Rheumatoid or arthritic conditions?
Y N DK/U Endocrine or thyroid problems?
Y N DK/U Kidney problems?
Y N DK/U Diabetes?
Y N DK/U Cancer, tumor, radiation treatment or chemotherapy?
Y N DK/U Stomach ulcer or hyperacidity?
Y N DK/U Polio mononucleosis, tuberculosis, or pneumonia?
Y N DK/U Problems of the immune system?
Y N DK/U Aids or HIV positive?
Y N DK/U Hepatitis, jaundice, or liver problem?
Y N DK/U Fainting spells, seizures, epilepsy, or neurological problem?
Y N DK/U Mental health disturbance or behavioral problem?
Y N DK/U Vision, hearing, or speech difficulties?
Y N DK/U Loss of weight recently or poor appetite?
Y N DK/U History or eating disorder (anorexia, bulimia)?
Y N DK/U Excessive bleeding or bleeding tendency, anemia, or bleeding disorder?
Y N DK/U High or low blood pressure?
Y N DK/U Tires easily?
Y N DK/U Chest pain, shortness of breath, or swelling ankles?
Y N DK/U Cardiovascular problem (heart trouble, heart attack, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)?
Y N DK/U Skin disorder?
Y N DK/U Does the patient eat a well-balanced diet?
Y N DK/U Frequent headaches, colds, or sore throats?
Y N DK/U Eye, ear, nose, or throat condition?
Y N DK/U Hayfever, asthma, sinus trouble, or hives?
Y N DK/U Tonsil or adenoid conditions?
Y N DK/U Osteoporosis?

**Allergies or reactions to any of the following:**

Y N DK/U Local anesthetics (Novocaine or Lidocaine)?
Y N DK/U Aspirin?
Y N DK/U Ibuprofen (Motrin, Advil)?
Y N DK/U Penicillin or other antibiotics?
Y N DK/U Sulfa drugs?
Y N DK/U Codeine or other narcotics?
Y N DK/U Metals (jewelry, clothing snaps)?
Y N DK/U Latex (gloves, balloons)?
Y N DK/U Vinyl?
Y N DK/U Acrylic?
Y N DK/U Animals?
Y N DK/U Foods (specify) ____________________________
Y N DK/U Other substances (specify) ____________________

Y N DK/U Are you taking medication, nutrient supplements, herbal medications, or non prescription medicine?

Medication: _______________ Taken for: ______________________

Medication: _______________ Taken for: ______________________

Medication: _______________ Taken for: ______________________

Y N DK/U Do you currently have or have you ever had a substance abuse problem?
Y N DK/U Do you chew or smoke tobacco?
Y N DK/U Operations? Describe: ________________________
Y N DK/U Hospitalized? For: ___________________________
Y N DK/U Other physical problems or symptoms? Describe: ____________________________________
Y N DK/U Being treated by another healthcare professional? For: ________________________________________

Date of most recent physical exam: ___________________________

Do you have any other medical conditions that we should be aware of?

________________________________________________________

### WOMEN ONLY

Y N DK/U Are you pregnant?
Y N DK/U Are you anticipating becoming pregnant?

### FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had, any of the following health problems? If so, please explain.

Bleeding disorders: ______________ Diabetes: _________________

Arthritis: ______________ Metabolic disturbances: _______________

Severe Allergies: ___________ Unusual dental problems: ____________

Jaw size imbalance: ______________

Any other family medical conditions that we should be aware of?

________________________________________________________

### DENTAL HISTORY

**Now or in the past, has the patient had:**

Y N DK/U Permanent/"extra" (supernumerary) teeth removed?
Y N DK/U Chipped or otherwise injured primary (baby) or permanent teeth?
Y N DK/U Supernumery (extra) or congenitally missing teeth?
Y N DK/U Teeth sensitive to hot or cold; teeth throb or ache?
Y N DK/U Jaw fractures, cysts, or mouth infections?
Y N DK/U "Dead teeth" or root canals treated?
Y N DK/U Bleeding gums, bad taste or mouth odor?
Y N DK/U Periodontal "gum problems"?
Y N DK/U Food impactions between teeth?
Y N DK/U "Gum boils", frequent canker sores or cold sores?
Y N DK/U Thumb, finger, or sucking habit? Until what age? _____
Y N DK/U Abnormal swallowing habit (tongue thrusting)?
Y N DK/U History of speech problems?
Y N DK/U Mouth breathing habit, snoring, or difficulty breathing?

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Y N DK/U Any pain or soreness in the muscles of the face or around the ears?
Y N DK/U Difficulty in chewing or jaw opening?
Y N DK/U Ever been treated for "TMD" or "TMJ" problems?
Y N DK/U Aware of loose, broken, or missing restorations (fillings)?
Y N DK/U Aware or concerned about under or over developed jaw?
Y N DK/U Any relative with similar tooth or jaw relationships?
Y N DK/U Any wisdom tooth problems?
Y N DK/U Had periodontal (gum) treatment?
Y N DK/U Been under another dentist's care?
Specialist: ______________________________
Other: ______________________________

Y N DK/U Tooth grinding or jaw clenching?
Y N DK/U Any teeth irritating cheek, lip, tongue, or palate?
Y N DK/U Concerned about spaced, crooked, or protruding teeth?
Y N DK/U Ever had a prior orthodontic examination or treatment?
Y N DK/U Had any serious trouble associated with any previous dental treatment?
Y N DK/U Would you object to wearing orthodontic appliances (braces) should they be indicated?

What is your primary concern for your teeth? ____________________
______________________________________________________
______________________________________________________
______________________________________________________

## EMERGENCY CONTACT INFORMATION

In the event of an emergency, is there someone who lives near you that we could contact?

His/Her Name: ______________________________

Relation: ______________________________

Work #: ____________________ Home #: ____________________

Nearest Relative: ______________________________

Relation: ______________________________

Address: ______________________________

Work #: ____________________ Home #: ____________________

## THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

I understand that the information that I have given is correct to the best of my knowledge.
I also understand that it is my responsibility to inform this office of any changes in my medical status.
This office reserves the right to verify the credit status of potential patients and/or parents of patients.

______________________________
Signature

______________________________
Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

## OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials ________ Date ________

Doctors Comments:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________