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

Hall Orthodontics

DENISE A. HALL, DMD, MS

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOUR CHILD

Today's Date: ____

Child's Name: ____
LAST MIDDLE FIRST

Nickname: ______________________ Male Female

Child's Birthdate: ____/____/____ Child's Age: ______________

School: _________________________________ Grade: _______

Hobbies/Sports: ______________________________________

Child's Home #: ______________________________________

Child's Home Address: _________________________________

____

General Dentist: ______________________________________

Dentist's Address: ____________________________________

Last Visit Date: _______________________________________

What is your email address to remind you of your appointments?

Email: ____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: ________________________ Relation: ______________

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? ____________________

List brother/sisters with age: _________________________

Parent's Marital Status: Single Married Divorced Separated Widowed

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: _______________________________

GENERAL INFORMATION

Mother's Information: Step Mother Guardian

Name: __________________________ Birthdate: ____/____/____

Wk#: ______________ Ext.: _______ SS#: ________________

Employer: ____

Employer Address: _____________________________________

How long at current job: ________ Job Title: _______________

Who is responsible for the account? _____________________

Father's Information: Step Father Guardian

Name: __________________________ Birthdate: ____/____/____

Wk#: ______________ Ext.: _______ SS#: ________________

Employer: ____

Employer Address: _____________________________________

How long at current job: ________ Job Title: _______________

Who is responsible for making the appointments? ____________

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MEDICAL HISTORY

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

Y N DK/U Does patient follow directions well?
Y N DK/U Does patient have learning disabilities or need extra help with instructions?
Y N DK/U Is the patient sensitive or self-conscious about teeth?

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 issue (heart trouble, inborn heart defects, heart attack, coronary insufficiency, rheumatic heart disease, arteriosclerosis, heart murmur, or stroke)?
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?

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: ___________________________

Other medical conditions that we should be aware of? _______________

GIRLS ONLY

Y N DK/U Has the patient started monthly periods? When? _____
Y N DK/U Is the patient 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? __________________________

DENTAL HISTORY

Now or in the past, has the patient had:

Y N DK/U Started teething early or late?
Y N DK/U Primary (baby) teeth removed that were not loose?
Y N DK/U Supernumery (extra) or congenitally missing teeth?
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 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?
Y N DK/U Any pain in the jaw or ringing in the ears?

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Y N DK/U Taking any forms of fluoride?
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:

____
____
____
____
____
____
____
____
____

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