



# Welcome to our office!

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Orthodontic & Dentofacial Orthopedics



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## NEW PATIENT REGISTRATION FORM (FOR PATIENTS OVER AGE 18)

www.hessorthodontics.com

The information provided is strictly confidential.



### PATIENT INFORMATION

Patient's Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Today's date: \_\_\_/\_\_\_/\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home phone: \_(\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Close friend/relative who is a patient here \_\_\_\_\_

Brothers/Sisters or Sons/Daughters (name/ages): \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_ School/Grade: \_\_\_\_\_

Previous orthodontic consultation? Yes / No If so, when/where? \_\_\_\_\_

In your opinion, what is your orthodontic problem? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_ Relationship to pt.: \_\_\_\_\_ Marital Status: S / M / W / D

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home phone: \_(\_\_\_\_) \_\_\_\_\_ Cell/Work #: \_(\_\_\_\_) \_\_\_\_\_

Social Security: \_\_\_ - \_\_\_ - \_\_\_ Drivers License #: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Email address: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to pt: \_\_\_\_\_

Home phone: \_(\_\_\_\_) \_\_\_\_\_ Cell/Work #: \_(\_\_\_\_) \_\_\_\_\_

Social Security: \_\_\_ - \_\_\_ - \_\_\_ Drivers License #: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_ Years: \_\_\_\_\_

Do you have orthodontic insurance coverage? Yes / No If yes, please fill out insurance form. Thanks!

**Please complete both sides**

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DENTAL INFORMATION

How does the patient feel about wearing "braces": \_\_\_\_\_

Does anyone else in the family need orthodontics? Yes / No If yes who? \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Does the patient have regular checkups? Yes / No

Last Dental Exam: \_\_\_\_\_ Last Dental X-Rays: \_\_\_\_\_

Other Dental Specialists: \_\_\_\_\_

Have you been satisfied with past dentistry? Yes / No If no, please explain \_\_\_\_\_

Does the patient currently have, or have had any of the following? (please circle)

- |                        |                                     |
|------------------------|-------------------------------------|
| Thumb/finger habit     | Head/neck injury                    |
| Nail biting            | Jaw/joint pain/head/neck pain       |
| Periodontal disease    | Cold sores/clenching/grinding       |
| Gum surgery/food traps | Adult/baby/wisdom tooth extractions |

Is there any other dental information we should know about? \_\_\_\_\_

MEDICAL INFORMATION

Physician's Name: \_\_\_\_\_ Patient's overall health: Excellent / Good / Poor

Is the patient allergic to anything (drugs/food/pollen): \_\_\_\_\_

Is the patient currently under medical care? Yes / No Where/When? \_\_\_\_\_

Is the patient currently taking medications? Yes / No Please list: \_\_\_\_\_

Has the patient ever been hospitalized? Yes / No Where/When? \_\_\_\_\_

Does the patient currently have, or have had any of the following? (please circle)

- |                    |                     |                       |
|--------------------|---------------------|-----------------------|
| Adenoid removed    | Drug history        | Major surgery         |
| AIDS (HIV)         | Epilepsy/seizures   | Nasal/airway problems |
| Arthritis          | Heart problems      | Sinus problems        |
| Asthma             | Hepatitis A,B, or C | Speech problems       |
| Auto accident      | High blood pressure | Tobacco usage         |
| Bleeding disorders | Immune disorders    | Tonsils removed       |
| Cancer             | Kidney problems     | Tuberculosis          |
| Cosmetic surgery   | Liver problems      | Tubes in ears         |
| Diabetes           | Lung problems       | Venereal disease      |

EMERGENCY INFORMATION

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Work #: (\_\_\_\_) \_\_\_\_\_

\*Signature: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_