



Welcome to our office!

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Orthodontic & Dentofacial Orthopedics



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NEW PATIENT REGISTRATION FORM (FOR PATIENTS UNDER 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

Father's Name: _____ Marital Status: S / M / W / D

Address: _____ City, State, Zip: _____

Home phone: _(____) _____ Cell/Work #: _(____) _____

Social Security: ____ - ____ - ____ Drivers License #: _____ Birthdate: ___/___/___

Mother's Name: _____ Marital Status: S / M / W / D

Home phone: _(____) _____ Cell/Work #: _(____) _____

Social Security: ____ - ____ - ____ Drivers License #: _____ Birthdate: ___/___/___

Email address: _____

If divorce is involved, who is the Custodial Parent? _____

May patient information be released to the non-custodial parent? Yes / No

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: ____/____/____