ROBERT H. HAMBLETON, D.D.S., INC.

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

LINDSEY H. MACFARLANE, D.D.S., M.S., INC.

200 SOUTH OAK KNOLL AVENUE ▪ SUITE 201 ▪ PASADENA, CALIFORNIA 91101 ▪ 626-795-0634 ▪ FAX 626-449-4086

HambletonOrthodontics@gmail.com

Date _____

PATIENT INFORMATION (Please Print)

Patient's Name _____ (Last) (First) (MI)

Address _____ (Street) (City) (Zip Code)

Phone (_____) _____ Date of Birth _____ (Month / Day / Year) (Age) M ☐ F ☐

Social Security Number _____

Employer _____ Occupation _____

Work Address _____ (Street) Work Phone (_____) _____

_____ (City) (Zip Code) e-mail _____

Referred By _____

Dentist _____ Physician _____

Phone (_____) _____ Phone (_____) _____

Emergency Contact: _____ Phone (_____) _____

Is patient covered by orthodontic insurance? **Yes** ☐ **No** ☐

If Yes, please complete the following information.

IF YOU HAVE COVERAGE FROM MORE THAN ONE COMPANY, PLEASE GIVE ALL INFORMATION FOR EACH COMPANY.

_____

Name of Insurance Company | Name of Policy Holder(s) | SS# | Date of Birth

_____

Policyholder(s) Employer(s) | Union Local Number(s) | Employer Group Number(s)

Person Responsible for Account _____
(If person other than above please give address, phone and relationship)

_____

Name of Insurance Company | Name of Policy Holder(s) | SS# | Date of Birth

_____

Policyholder(s) Employer(s) | Union Local Number(s) | Employer Group Number(s)

Person Responsible for Account _____
(If person other than above please give address, phone and relationship)

DENTAL HISTORY

Date of last dental cleaning _____ other treatment _____

Family history of orthodontic problems _____

Were there any habits which have caused the teeth to move? nail or lip biting ☐ grinding ☐ clenching ☐

What is your main concern? _____

	YES	NO
Any injuries to face, mouth, or teeth in the past?	☐	☐
Does the patient have any speech problems?	☐	☐
Are there any missing or extra permanent teeth?	☐	☐
List any musical instruments played by mouth _____		
Does patient have sore or sensitive teeth?	☐	☐
Has patient ever had any orthodontic treatment?	☐	☐

	YES	NO
Is patient self-conscious about appearance of teeth?	☐	☐
Has a dentist shown patient how to clean his/her teeth?	☐	☐

How often does patient brush his/her teeth? _____

List type of toothbrush (hard, medium, soft) _____

List any other aids (floss, stimulant, water spray device, rubber tip, or toothpick) and how often used _____

Additional general dental information: _____

MEDICAL HISTORY

Date of last medical care _____ Reason: _____

Has patient been hospitalized in the last 2 years? ☐ YES ☐ NO Reason: _____

Health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does patient have a reaction to any of the following? (Please check and describe fully under remarks):

	YES	NO
1. **ALLERGIES**		
a. Penicillin	☐	☐
b. Other Antibiotics _____	☐	☐
c. Others _____	☐	☐
2. Arthritis	☐	☐
3. Asthma	☐	☐
4. Blood disease or Abnormal Bleeding Problems	☐	☐
a. Anemia	☐	☐
b. Clotting Problems	☐	☐
c. Other Blood Disorders	☐	☐
5. Diabetes	☐	☐
Taking medications _____	☐	☐
If yes, please list _____	☐	☐
_____	☐	☐
6. Chest pains, ankle swelling, or shortness of breath?	☐	☐
7. Epilepsy	☐	☐
8. Fainting	☐	☐
9. Glandular disease (thyroid, etc.)	☐	☐
10. Heart Disease	☐	☐
11. Heart Murmur	☐	☐
12. Rheumatic Fever	☐	☐
13. High Blood Pressure	☐	☐
14. Low Blood Pressure	☐	☐
15. Kidney Disease	☐	☐
16. Liver Disease, Hepatitis, Jaundice	☐	☐
17. AIDS / HIV +	☐	☐
18. Radiation Treatment	☐	☐
19. Respiratory Disease	☐	☐
20. Stomach or Duodenal Ulcers	☐	☐
21. Tumor History	☐	☐
22. Psychiatric Treatment	☐	☐
	☐	☐
23. Emotional / Behavioral Problems _____	☐	☐
_____	☐	☐
24. Other Medical Conditions _____	☐	☐
_____		

25. Has patient had excessive bleeding requiring treatment? _____	☐	☐
26. Is patient taking medicine, drugs or pills regularly? _____	☐	☐
27. Has patient experienced any unfavorable reaction to previous dental treatment? _____	☐	☐
28. DOES PATIENT REQUIRE PRE-MEDICATION, PRIOR TO DENTAL TREATMENT?	☐	☐

IF SO, NAME OF MEDICATION _____

29. Is there any other information we should know? _____

_____

_____

_____

_____

_____

_____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the care of the patient named above. I also accept full responsibility for the payment of such services.

Signed _____ Date _____

Patient, Parent or Guardian (Must be 18 years or older) Signature

For Office Use