



HAMBLETON & MACFARLANE

ORTHODONTICS

EST. 1955

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Date _____

PATIENT INFORMATION (Please Print)

Patient's Name _____
Last First MI

Address _____
Street City Zip Code

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

Social Security Number _____

Employer _____

Occupation _____

Work Address _____

Work Phone (_____) _____

Street
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

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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?

Additional general dental information: _____

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 _____

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):

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

25. Has patient had excessive bleeding requiring treatment? _____ YES NO

26. Is patient taking medicine, drugs or pills regularly? _____ YES NO

27. Has patient experienced any unfavorable reaction to previous dental treatment? _____ YES NO

28. DOES PATIENT REQUIRE PRE-MEDICATION, PRIOR TO DENTAL TREATMENT? YES NO

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