HAMBLETON
& MACFARLANE
ORTHODONTICS
EST. 1955

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PATIENT INFORMATION (Please Print)

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Prefers to be called)

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

Phone (_____) _____

Patient's Date of Birth _____ (Month / Day / Year) Age M ☐ F ☐

Referred By _____

School _____

E-mail _____

Siblings _____

Cell Phone (_____) _____

Emergency Contact _____

Dentist _____

Phone (_____) _____

Physician _____

Mother's Name _____

Father's Name _____

Date of Birth _____

Date of Birth _____

Social Security Number _____

Social Security Number _____

Home Address (if different from pt.) _____

Home Address (if different from pt.) _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Work Address _____

Work Address _____

Phone (_____) _____ (Home) (_____) _____ (Work)

Phone (_____) _____ (Home) (_____) _____ (Work)

Person Responsible for Account (if person is not listed above please give address, phone & relationship) _____

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.

1. _____ (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))

2. _____ (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))

DENTAL HISTORY

Date of last dental cleaning _____ How often? _____

Family history of orthodontic problems _____

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

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 _____

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

Health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does your child 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.)	☐	☐

	YES	NO
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, BASED ON PHYSICIAN INSTRUCTION/PERSONAL REFERENCE, 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 to the care of the patient named above. I also acknowledge full responsibility for the payment of such services and agree to pay for them.

Signed _____ Date _____

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

For Office Use

Treatment Time _____

Treatment Fee _____

Initial Fee _____ Monthly _____ Contract Sent _____