ADULT ◆ ACQUAINTANCE ◆ FORM

HARDIE ORTHODONTICS
Diplomate American Board of Orthodontics
Practice Limited To Orthodontics

Date: _____

Patient's Name _____ (LAST) _____ (FIRST) _____ (MI)

Patient's Age _____ Date of Birth _____ ◇Male ◇Female

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP) Phone _____

Cell phone _____ Email _____

Employer _____ Occupation _____

Work Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Work phone _____ Referred by _____

Insurance Co. _____ SSN or ID No. _____

Insurance Co. Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Insurance Phone _____ Group No. _____

Patient's dentist _____ Patient's physician _____

Name and ages of children in family _____

First

Spouse's Information

Spouse's name _____ (LAST) _____ (FIRST) _____ (MI) Date of birth _____

Employer _____ Occupation _____

Work Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Work phone _____ Referred by _____

Insurance Co. _____ SSN or ID No. _____

Insurance Co. Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Insurance Phone _____ Group No. _____

Last

Medical History

Are you in good health? ◇ Yes ◇ No

Do you have any history of major illness? ◇ Yes ◇ No

Have you ever been treated for an illness? ◇ Yes ◇ No

Are you prone to the following? ◇ Yes ◇ No
Colds?
Sore Throats?
Ear Infections?

Have your tonsils/adenoids been removed? ◇ Yes ◇ No
If so, at what age? _____

Check any of the following for which you have been treated:

Diabetes	◇Yes ◇No		Kidney involvement	◇Yes ◇No	
Pneumonia	◇Yes ◇No		Tuberculosis	◇Yes ◇No	
Heart Trouble	◇Yes ◇No		AIDS	◇Yes ◇No	
Rheumatic Fever	◇Yes ◇No		Prolonged Bleeding	◇Yes ◇No	
Bone disorder	◇Yes ◇No		Fainting/dizziness	◇Yes ◇No	
Herpes	◇Yes ◇No		Nervous disorders	◇Yes ◇No	
Anemia	◇Yes ◇No		Liver involvement	◇Yes ◇No	
Epilepsy	◇Yes ◇No		Endocrine problems	◇Yes ◇No	
Asthma	◇Yes ◇No				

List any drugs/medications you are taking and for what reasons: _____

List any allergy or drug sensitivity that you have: _____

Do you have any other medical conditions not described above?
If yes, please explain: _____

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Last _____ First _____

Dental History

Have there been any injuries to your face/mouth/teeth? ◇Yes ◇No

Do you have any missing teeth? ◇Yes ◇No

Do you have any speech problems? ◇Yes ◇No

Do you have any primary teeth? ◇Yes ◇No

Are you a mouth-breather? ◇Yes ◇No

While awake? ◇Yes ◇No

While asleep? ◇Yes ◇No

Has an orthodontist been consulted? ◇Yes ◇No

Date of last cleaning at Dentist _____

Reason for consultation: _____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical/dental status.

We will discuss your treatment with person(s) financially responsible for your treatment/referring doctor/dentist for the furtherment of your treatment.

By signing this, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

Thank you for filling out this form completely. It will enable us to provide you with better orthodontic care.

For Official Office Use

Study Model # _____

Date _____ Dr./Asst. _____ (Signature)

Cl=R _____ OB= _____ OJ= _____ Mid= _____

X-brite= _____ Crowding= ↑ _____ ; ↓ _____ Profile= _____

CARIES Noted Yes/No _____ Hygiene _____ OCS= _____ JAWS= _____

Fee est./Time est. _____ N/V _____