Welcome to the Orthodontist!

Today's Date: ___/___/____

We would like to welcome you to Hardy Orthodontics! Please fill out the form below and bring it with you to your first appointment.

Name: _____ Nickname: _____
Last First MI

☐ Male ☐ Female Birthdate: ___/___/____ Age: ____ Home #: _____

Home Address: _____
Street Apt# City State Zip

Whom may we thank for referring you? _____

E-Mail Address_____

Patient's Information:

General Dentist:_____ Last Visit Date: ___/___/____

Social Security #: _____

Employer: _____ Work #: _____

How long at current job? _____ Job Title: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Information:

Name: _____ Birthdate: ___/___/____

Social Security #: _____

Employer: _____ Work #: _____

How long at current job? _____ Job Title: _____

Primary Orthodontic Insurance:

Orthodontic Coverage? ☐ Yes ☐ No Insurance Company Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group #: _____

Policy Owner's Name: _____ Relation: _____

Policy Owner's Birthdate: ___/___/____ Policy Owner's SS #: _____

Policy Owner's Employer: _____

Secondary Orthodontic Insurance:

Orthodontic Coverage? □ Yes □ No Insurance Company Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____ Group #: _____

Policy Owner's Name: _____ Relation: _____

Policy Owner's Birthdate: ___/___/____ Policy Owner's SS #: _____

Policy Owner's Employer: _____

What are the main concerns that you would like orthodontics to accomplish? _____

_____ _____

Have you ever been evaluated for or had orthodontic treatment before? □ Yes □ No
Have there been any injuries to the face, mouth, teeth or chin? □ Yes □ No
Have adenoids or tonsils been removed? □ Yes □ No

Have you ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment	Y	N	Clenching/Grinding Teeth
Y	N	Allergies to any Drugs	Y	N	Heart Murmur	Y	N	Lip Sucking/Biting
Y	N	Allergies to Latex/Metals	Y	N	Hepatitis	Y	N	Mouth Breather
Y	N	Asthma	Y	N	HIV+/AIDS	Y	N	Nail Biting
Y	N	Cancer	Y	N	Kidney/Liver Problems	Y	N	Speech Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic/Scarlet Fever	Y	N	Thumb/Finger Sucking
Y	N	Convulsions/Epilepsy	Y	N	Tuberculosis (TB)	Y	N	Tongue Thrust
Y	N	Diabetes						

Please discuss any medical problems that you have had: _____

_____

Physician's Name: _____ Phone #: _____

Date of Last Visit: ___/___/____ Are you currently under the care of a physician? □ Yes □ No

Please describe your current physical health: □ Good □ Fair □ Poor

Please list all drugs you are currently taking: _____

_____

Please list all drugs you are allergic to: _____

_____

- This office reserves the right to verify the credit status of patients prior to extending credit for treatment fees.
- I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: ___/___/____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.