HAMER&GLASSICK
ORTHODONTICS

A B C

ADULT PATIENT INFORMATION

Date_____

Patient's name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Previous Address (If less than 3 years)_____

Cell Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician_____ Date of Last Visit _____
Address_____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

Check any of the medical conditions below that you have had or currently have.

☐ Abnormal bleeding/Hemophilia	☐ Diabetes	☐ Hepatitis/Liver problems	☐ Pneumonia
☐ Anemia	☐ Dizziness	☐ Herpes	☐ Prolonged Bleeding
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Radiation/Chemotherapy
☐ Asthma or Hayfever	☐ Gastrointestinal Disorders	☐ HIV / Aids	☐ Rheumatic Fever
☐ Bone Disorders	☐ Heart Problems	☐ Kidney problems	☐ Tuberculosis
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Nervous Disorders	☐ Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

☐ Yes ☐ No Are you presently in any dental pain? _____
☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry? _____
☐ Yes ☐ No Have your wisdom teeth been removed? _____
☐ Yes ☐ No Have you ever lost or chipped any teeth? _____
☐ Yes ☐ No Have there been any injuries to face, mouth, or teeth? _____
☐ Yes ☐ No Is any part of your mouth sensitive to temperature? Where? _____
☐ Yes ☐ No Is any part of your mouth sensitive to pressure? Where? _____
☐ Yes ☐ No Do your gums bleed when you brush? _____
☐ Yes ☐ No Do you have any type of thumb or tongue habit? _____
☐ Yes ☐ No Are you a mouth breather? _____
☐ Yes ☐ No Have you ever seen an orthodontist? If yes, who and when? _____
☐ Yes ☐ No What is your attitude toward receiving orthodontic treatment? _____
☐ Yes ☐ No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
☐ Yes ☐ No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
☐ Yes ☐ No Are you aware of your jaw clicking or popping? _____
☐ Yes ☐ No Are you aware of clenching your teeth during the day? _____
☐ Yes ☐ No Have you ever been told that you grind your teeth? _____
☐ Yes ☐ No Do you have “tension” headaches? _____
☐ Yes ☐ No Have you ever experienced chronic ringing in your ears? _____
☐ Yes ☐ No Are you aware that some appointments will be during work hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____