HALL & BURNETT PATIENT INFORMATION

Patient's Last Name | Patient's Legal First Name | Patient's Middle Name | Patient Prefers to be Called

Patient's DOB | Patient's Age | Patient's E-Mail Address | Gender M/F

Patient's Street Address | Patient's City, ST Zip | Patient's Home # | Patient's Cell #

Whom may we thank for referring you to our office?

Are other family members treated here? Yes No If so, who?

Sibling/Children information:

Sibling/Child Full Name | M/F | Sibling/Child DOB | Sibling/Child Full Name | M/F | Sibling/Child DOB

RESPONSIBLE PARTY INFORMATION

Resp. Party's Last Name: | Resp. Party's First Name | Resp. Party's E-mail Address | Relationship to Patient

Marital Status: Single Married Divorced Widowed Separated

Resp. Party's Street Address | Resp. Party's City, ST Zip | Resp. Party's Home # | Resp. Party's Work # | Resp. Party's Cell #

Resp. Party's Social Security # | Resp. Party's Employer | Resp. Party's Occupation | # Yrs at Employer | Resp. Party's DOB

Secondary Resp. Party's Last Name: | Secondary Resp. Party's First Name | Secondary Resp. Party's E-mail Address | Relationship to Patient

Marital Status: Single Married Divorced Widowed Separated

Secondary Resp. Party's Street Address | Resp. Party's City, ST Zip | Resp. Party's Home # | Resp. Party's Work # | Resp. Party's Cell #

Resp. Party's Social Security # | Resp. Party's Employer | Resp. Party's Occupation | # Yrs at Employer | Resp. Party's DOB

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Last Name | Insured's First Name | Insured's Soc. Sec. # | Insurance Co. Name | Insured's Group #

Insurance Co.'s Street Address | Insurance Co.'s City, ST Zip | Insurance Co.'s # | Insured's' Employer | Insured's DOB

Do you have dual insurance coverage? Yes No **Do you have a pre-tax flexible spending account? Yes No**

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Last Name | Insured's First Name | Insured's Soc. Sec. # | Insurance Co. Name | Insured's Group #

Insurance Co.'s Street Address | Insurance Co.'s City, ST Zip | Insurance Co.'s # | Insured's' Employer | Insured's DOB

EMERGENCY INFORMATION – RELATIVE OR FRIEND NOT LIVING WITH YOU

Emergency Contacts Name | Relationship to Patient | Best Contact Phone # | Secondary Contact Phone #

Patient's Name | Patient's Dentist | Last Dental Visit

Orthodontic	Dental	Medical
Has an orthodontist been previously consulted? ☐ yes ☐ no	**What was your dentist's main concern?**	**Physician's Name:** **Last physical exam:**
In your own words, describe your orthodontic problems and what would you like orthodontics to accomplish?	**Is there any dental work that needs to be completed prior to orthodontic treatment?** ☐ yes ☐ no	**Is Patient under the care of a physician at this time?** ☐ yes ☐ no **If yes, please explain reason for physician's care:**
Indicate the patient's feelings toward orthodontic treatment? ☐ eager to get started ☐ complacent ☐ not committed to cooperate	**Are antibiotics necessary for teeth cleanings?** ☐ yes ☐ no	**List any medications being taken at this time:** **Has Patient currently or previously taken bisphosphonates?** ☐ yes ☐ no
Hobbies/Comments:	**What was the date of your last cleaning?**	**List any drugs/things that Patient is allergic to or has a reaction to:**

Please check yes or no if Guest currently has or has had:

Abnormal Adenoids/Tonsils	☐ yes ☐ no	Endocrine problems	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no
AIDS/HIV	☐ yes ☐ no	Epilepsy	☐ yes ☐ no	Prolonged bleeding	☐ yes ☐ no
Allergy/Sinus trouble	☐ yes ☐ no	Faintness/Dizziness	☐ yes ☐ no	Psychiatric treatment	☐ yes ☐ no
Anemia Epilepsy/Convulsions	☐ yes ☐ no	Fever blisters	☐ yes ☐ no	Rad/Chemo/Blood therapy	☐ yes ☐ no
Arthritis/Thyroid problems	☐ yes ☐ no	Headaches (frequent)	☐ yes ☐ no	Respiratory problems	☐ yes ☐ no
Artificial heart valves	☐ yes ☐ no	Heart murmur	☐ yes ☐ no	Rheumatic/Scarlet/Yellow fever	☐ yes ☐ no
Asthma	☐ yes ☐ no	Heart trouble	☐ yes ☐ no	Scoliosis	☐ yes ☐ no
Bone disorders	☐ yes ☐ no	Finger/Thumb/Lip sucking	☐ yes ☐ no	Shortness of breath	☐ yes ☐ no
Blood disease	☐ yes ☐ no	Hemophiliac	☐ yes ☐ no	Stroke	☐ yes ☐ no
Bruxing/Grinding	☐ yes ☐ no	Hepatitis	☐ yes ☐ no	TMJ problems	☐ yes ☐ no
Cancer	☐ yes ☐ no	Herpes	☐ yes ☐ no	Thyroid problems	☐ yes ☐ no
Cardiac pacemaker	☐ yes ☐ no	High/Low Blood pressure	☐ yes ☐ no	Tonsils removed	☐ yes ☐ no
Congenital heart lesions	☐ yes ☐ no	Jaundice	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Chronic cough	☐ yes ☐ no	Joint swelling	☐ yes ☐ no	Disabilities	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Kidney disease	☐ yes ☐ no	Venereal disease	☐ yes ☐ no
Drug addiction	☐ yes ☐ no	Liver disease	☐ yes ☐ no	Wound healing problems	☐ yes ☐ no
Ear problems	☐ yes ☐ no	Organ transplant	☐ yes ☐ no	Whiplash	☐ yes ☐ no
Emotional problems	☐ yes ☐ no	Muscle or joint disorder	☐ yes ☐ no		
Is the patient pregnant?	☐ yes ☐ no	Is bite uncomfortable?	☐ yes ☐ no	Cheek, tongue or lip chewing?	☐ yes ☐ no
Has patient reached puberty?	☐ yes ☐ no	Jaw symptoms/headaches?	☐ yes ☐ no	Clenching teeth?	☐ yes ☐ no
Any facial injuries?	☐ yes ☐ no	Trauma to the jaw?	☐ yes ☐ no	Grinding teeth?	☐ yes ☐ no
Mouth breathing?	☐ yes ☐ no	Does the patient smoke?	☐ yes ☐ no	Fingernail habit?	☐ yes ☐ no
Missing/extra permanent teeth?	☐ yes ☐ no	Abnormal height or weight?	☐ yes ☐ no		
Speech problems?	☐ yes ☐ no	Adopted? Does he/she know?	☐ yes ☐ no		
Pain/clicking upon opening mouth?	☐ yes ☐ no	Latex allergy?	☐ yes ☐ no		

Please explain ANY Diseases, Medical or Dental Conditions that are not mentioned above:

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs in order to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in medical status. I understand that when appropriate credit bureau reports may be obtained.

Signature (Parent's signature if minor) | Date

Date Updated | Initial | Date Updated | Initial | Date Updated | Initial