Hodges Orthodontics

101 N. Davis Street
Sulphur Spring, TX 75482
903-885-2800

ADULT PATIENT INFORMATION

Today's Date: _____
Name:_____ Prefer to be called: _____ Sex: _____
Age: _____ Birthdate: _____ Social Security #: _____-_____-_____ Married Single Divorced Widowed
Spouse's Name: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Email Address: _____
Occupation: _____ Employer: _____
Dentist: _____
Do you know a patient currently in our practice? If so, whom: _____
Has any member of the family had orthodontic treatment? If so, by whom?:_____
Please list names of other family members treated in our office: _____
Who noticed your orthodontic problem? Self Dentist Other _____
Describe your orthodontic problem in your own words: _____
What concerns you most about orthodontic treatment?
Appearance in appliances Cost Length of time Discomfort Results Other _____
If you could change anything about your smile, what would it be? _____
Whom may we thank for referring you to our office? _____

ACCOUNT INFORMATION

Person responsible for account: _____
If other than self:
Name: _____ Occupation: _____
Address: _____ City: _____State: _____ Zip: _____

In case of emergency, please provide name, address and phone number of your nearest relative:
Name: _____ Address: _____
Phone #: _____

INSURANCE INFORMATION

Name of insured: _____ Date of Birth: _____
Social Security #: ____- ____ - _____ Insurance carrier/company: _____

MEDICAL HISTORY

Your answer to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept completely confidential.

Physician's Name: _____Address: _____ Phone:_____

Have you experienced any health problems?	No	Yes	Explain:_____
Any major change in your health recently?	No	Yes	Explain:_____
Are you currently under a physician's care?	No	Yes	Explain:_____
Are you allergic to any medications?	No	Yes	Explain:_____
Have you received a blood transfusion?	No	Yes	Explain:_____
Have your tonsils or adenoids been removed?	No	Yes	Explain:_____
Are you taking any medications?	No	Yes	Explain:_____

Hodges Orthodontics

101 N. Davis Street
Sulphur Spring, TX 75482
903-885-2800

Please check if you have had of the following conditions:

Heart Murmur……..	No	Yes	Hepatitis……..	No	Yes	Emotional Problems….	No	Yes
AIDS……..	No	Yes	Diabetes……..	No	Yes	Frequent Headaches..	No	Yes
Rheumatic Fever…….	No	Yes	Kidney Disease..	No	Yes	Nervous/Anxious……..	No	Yes
Endocrine disorders……	No	Yes	Liver Disease…..	No	Yes	Cancer……..	No	Yes
Prolonged Bleeding…….	No	Yes	Tuberculosis……	No	Yes	Bone Disorders……	No	Yes
Anemia …….	No	Yes	Bronchitis…….	No	Yes	Growth Disorders…….	No	Yes
Blood Disease……..	No	Yes	Asthma…….	No	Yes	Mouth Breather…….	No	Yes
Developmental Disorder..	No	Yes	Epilepsy……	No	Yes	Herpes(Fever Blisters)..	No	Yes
Hives/Rash……	No	Yes	Fainting…….	No	Yes	Tonsillitis……..	No	Yes

Have you ever had an unusual reaction to any drug such as penicillin, antibiotics, or aspirin? No Yes
If so, please explain: _____
Is there any other condition or problem that you think we should know about? _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone #:_____
Dental Specialist's Name: _____ Address: _____ Phone #: _____
Dental checkups: 2 times a year 1 times a year Only if problem exists Never Date of Last Visit: _____

Is there any unfinished care to be completed with your dentist?	No	Yes	Explain: _____
Are you frightened about dental treatment?	No	Yes	Explain: _____
Have you had an unpleasant experience in the dental office?	No	Yes	Explain: _____
Have you had any facial or dental injuries?	No	Yes	Explain: _____
Do you play any musical instruments?	No	Yes	What instrument? _____
Have you consulted an orthodontist previously?	No	Yes	Whom: _____
Have teeth (either primary or permanent) been removed?	No	Yes	
Have you had any previous orthodontic treatment?	No	Yes	Explain: _____
Are you satisfied with prior treatment?	No	Yes	Explain: _____
Any changes in your bite or dental alignment recently?	No	Yes	Explain: _____

Please circle if there is a history of:

Clenching teeth Muscular soreness around head & neck Jaw joint soreness
Jaw joint popping Grinding teeth Headaches (more than normal) Jaw joint clicking
Ringing in the ears Speech problems (if so what sounds?) _____
Mouth breathing- Awake or Asleep

Is there any other information that may be helpful? _____

I certify that the above information is complete and accurate. I also understand that I am responsible for updating any changes or additions to this information in the future. I consent to a financial agreement.

_____ _____
Patient signature Date Reviewed By Date