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:________________

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Please check if you have had of the following conditions:

Condition			Condition			Condition		
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