Hi 5 ORTHODONTICS

WELCOME TO HI 5 ORTHODONTICS!

DATE: _____ ____ MALE ___ FEMALE

PATIENT'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: (___) _____-_____ ___ CELL ___ HOME BIRTH DATE: ____/_____/____

PATIENT'S DENTIST: _____ DATE OF LAST VISIT: _____

RESPONSIBLE PARTY EMAIL: _____SCHOOL: _____

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REQUIRED – RESPONSIBLE/GUARDIAN INFORMATION

IF **YOU** ARE THE PATIENT, PLEASE FILL OUT THE HIGHLIGHTED ITEMS

NAME: _____
LAST FIRST MIDDLE **MARITAL STATUS**

MAILING ADDRESS: _____
STREET CITY STATE ZIP

HOW LONG AT THIS ADDRESS? _____ PHONE: (____) _____- _____ _____ CELL _____ HOME

SS #: _____ BIRTH DATE: _____ **RELATIONSHIP TO PATIENT:** _____

EMPLOYER: _____ **OCCUPATION:** _____ **NO. YEARS EMPL:** _____

ARE YOU: ___ TEACHER ___ MILITARY ___ POLICE ___ FIRE ?

****

SPOUSE'S/CO-PARENT: _____
LAST FIRST MIDDLE

SPOUSE'S/CO-PARENT EMPLOYER: _____ OCCUPATION: _____ ___NO. YEARS: _____

SS#: _____ BIRTH DATE: _____ PH: (____)_____ EMAIL: _____

IS YOUR SPOUSE: ___ TEACHER ___ MILITARY ___ POLICE ___ FIRE ?

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REQUIRED IF NOT PREVIOUSLY PROVIDED - INSURANCE INFORMATION

INSURED'S NAME: _____ DOB: _____ SS #: _____

INSURANCE CO: _____ GROUP #: _____

INSURANCE CO. ADDRESS: _____

INSURED'S EMPLOYER: _____

DO YOU HAVE DUAL COVERAGE? ___ YES ___ NO *IF YES, PLEASE CONTINUE,*

INSURED'S NAME: _____ DOB: _____ SS #: _____

INSURANCE CO: _____ GROUP #: _____

INSURANCE CO. ADDRESS: _____

INSURED'S EMPLOYER: _____

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In your own words, what is the problem?

_____

Have you seen another orthodontist? _____ Who? _____ Any treatment? _____

Family members treated here? _____ Who? _____

Their relationship to this patient: _____

Check all that apply (past or present):

☐ Baby teeth removed	☐ Frequent headaches	☐ Epilepsy or seizures	☐ Hepatitis A___ B___ C___
☐ Permanent teeth removed	☐ Periodontal Care	☐ Fainting or dizzy spells	☐ Aids ____ HIV ____
☐ Lip biting	☐ High Blood Pressure	☐ Tonsils/adenoids removed	☐ Chew Tobacco
☐ Nail biting	☐ Heart Murmur	☐ Allergies to meds: _____	☐ Smoke/vape Tobacco
☐ Clenching	☐ Anemia	☐ Allergies Other: _____	☐ Trauma to teeth: _____
☐ Grinding ___ day ___ night	☐ Other blood disorder _____	☐ Cleft lip/palate	_____
☐ Difficulty opening wide	☐ Prolonged bleeding	☐ Kidney disease	☐ Trauma to chin/jaws: ____
☐ Clicking or popping of jaws	☐ Sinus infections	☐ Heart disease	_____
☐ Earaches	☐ Asthma	☐ venereal disease	☐ Jaw surgery:_____
Airway and myofunction:			
☐ Tongue tie	☐ Speech difficulties	☐ bed wetting	☐ CPAP
☐ Tongue Thrust	☐ Snoring	☐ ADD ___ ADHD ___ ODD ___	☐ Other Sleep appliance: ___
☐ Mouth Breathing	☐ Sleep Apnea	☐ Had Sleep Study?	_____

Any other serious health disorder we should know about?_____

Any medications taken regularly? _____

What do you expect from orthodontic treatment? _____

Concerns? _____

Beyond having an exceptional new smile,

choose ONE benefit MOST important to you during your orthodontic experience?

____Atmosphere (we want to have fun!) ____Education (I need details on the why's and how's)

____Treatment Efficiency (faster is better) ____Scheduling (I have limited options with my schedule)

____Other Comments: _____

If you are planning to pay out of pocket for all or a portion of your orthodontic treatment, what is a comfortable down payment for you? $ _____.

To the best of my knowledge, all the preceding information is true and correct. If my (or my child's) health changes, or my medications change, I will inform the office as soon as possible.

Signature (guardian if patient is a minor): _____ Date: _____