DR. A.B. HAMMOND
Practice Limited to Orthodontics

Patient History Form

Interests: ____________________

Nickname: ____________________

EXAM	Date	Day	Time

Pts. Name	Sex M ☐ F ☐	Birth Date	AGE ______ Yrs. ______ Mos.
Address:		Height ______ Ft. ______ In.	Home Phone
School/Employer	Grade/Department		Work Phone

FATHER or Husband	Nickname	Height	OK To Contact At Office? YES ☐ NO ☐	Marital Status
Address:				Home Phone
Employer		Department		Work Phone
MOTHER or Wife	Nickname	Height:	OK To Contact At Office? YES ☐ NO ☐	Marital Status
Address:				Home Phone
Employer		Department		Work Phone

Referred by:

Siblings YES ☐ NO ☐	Name (BD) ______ (-)	______ (-)	______ (-)	______ (-)	______ (-)	
Siblings in Tx/Treated? YES ☐ NO ☐	Stage of Tx ______	______	______	______	______	

DENTAL HISTORY

Pt. Had Orthodontic Tx in Past? YES ☐ NO ☐	Orthodontist	City:	State:	Dentist: ______
Parent Had Orthodontic Tx? YES ☐ NO ☐	Father ☐ Mother ☐			Date of Last Dental Visit: ______
Dental Trauma? YES ☐ NO ☐	Trauma			Time/Day Brushes: 1 ☐ 2 ☐ 3 ☐ 4 ☐
Dental Notes (Canker Sores):				Extractions

Medical History

Physician:

OPERATIONS/HOSPITALIZATIONS YES ☐ NO ☐	Tonsils ☐ Adenoids ☐ Hospitalized ☐	
Chronic Disease? Heart ☐ Other ☐ NO ☐	Heart Trouble, Rheumatic Fever, Diabetes, Epilepsy, Kidney/Liver Involvement, Pneumonia, Mono, Arthritis, Gland or Bleeding Disorders, Childhood Diseases, Hepatitis, or Other? B.P.=OK ☐ High ☐ Low ☐	
Presently Under Medication? YES ☐ NO ☐	Medication:	
Allergies & Drug Reactions? YES ☐ NO ☐	Hay Fever ☐ Asthma ☐	Onset of Puberty: No ☐ Yes ☐
Head or Neck Pain? YES ☐ NO ☐	Head Ears ☐ TMJ Neck ☐ Back ☐ Shoulder ☐ Eyes ☐	
T.M.J. Symptoms? YES ☐ NO ☐	Click ☐ Popping ☐ Tired: During Meals ☐ Gum Chewing ☐	
Oral Problems? YES ☐ NO ☐	Habits: Grind ☐ Clench ☐ ______ Breathing: Nose ☐ Mouth ☐ Both ☐	Speech: Had Therapy? YES ☐ NO ☐
Instruments/Sports? YES ☐ NO ☐	Instruments: YES ☐ NO ☐	Sports? YES ☐ NO ☐
Medical Notes:		

Who 1st Noticed Problem?	How Does Pt. Feel About Braces:	GRADES: A B C D
Chief Concerns: ______		COOP. POTENTIAL ☐ G ☐ F ☐ P

Responsible Party: P ☐ M ☐ F ☐ Other ☐		Relation To PT:	Marital Status:
Address:		How Long at This Address	Home Phone:
Previous Address: (If Less Than 3 Years at the Above Address):			
Employer	Occupation:	Years Employed:	Work Phone:

Insurance? YES ☐ NO ☐ PHONE # DUAL Insurance? YES ☐ NO ☐ PHONE # Notes:

#1 INS. CO. Name	Address:		
Subscriber's Name: GUAR? ☐	Soc. Sec. Number:	Group Number:	Plan/Local Number:
#2 INS. CO. Name	Address:		
Subscriber's Name: GUAR? ☐	Soc. Sec. Number:	Group Number:	Plan/Local Number:

In Case We Can't Reach You:

Person To Contact: ______ Relationship: ______ Work Phone ______ Home Phone ______

Are there any medical problems NOT noted above that we should be aware of? Hemophilia? YES ☐ NO ☐; HIV+? YES ☐ NO ☐; Other? ☐ NO, If YES ☐ What?

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to this history record, I will so inform this practice. I hereby authorize necessary credit information to be obtained by this office. I hereby ☐ authorize, ☐ do not authorize the taking of x-rays for an initial diagnosis.

Deceased: Mother? ☐ Father? ☐

Is Child Adopted? YES ☐ NO ☐

______ Signature (Patient/Responsible Adult) ______ Date

New Patient Welcome Questionnaire

WELCOME ______________________________

Our practice is here to provide our patients with the best orthodontic treatment available today. But, our patients are also our friends. If you would, please answer the questions below so that we may get to know you better.

What name (or nickname) do you like to be called by? ______________________________

Are you originally from this area? ______________________________

What kind of music do you like, and who are your favorite performers or groups?

What type of books or movies do you like? ______________________________

What type of sports do you like? ______________________________

Do you have any pets? If so, what kind? ______________________________

What subject do you like most if attending school? ______________________________

What are your hobbies and what type of things do you like to collect? ______________________________

What else do you like to do with your spare time? ______________________________

Please list the names of any of your friends or relatives who come to our office.

THANK YOU.