Welcome

Hough Orthodontics
Creating Smiles...
Changing Lives

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Patient Information

Date: _____ Nickname: _____ SS #: _____
Patient's Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Cell Phone: _____ School: _____
Other Siblings: _____ Email: _____
Who may we thank for referring you? _____

Responsible Party Information

Who is responsible for the account? _____ Patient/Parent
Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed___

_ Father _ Step Father _ Guardian _ Spouse _ Self
Name: _____
SS#: _____ Date of Birth:_____
Email: _____ Cell Phone: _____
Employer:_____
Occupation: _____
No. of yrs. employed: ___ Work Phone: _____
Address: (if different from patient)
Street: _____
City: _____ State: ___ Zip:_____
How long at residence: ___ Home Phone: _____
Previous Address: (if less than 3 yrs)
Street: _____
City: _____ State: ___ Zip:_____

_ Mother _ Step Mother _ Guardian _ Spouse _ Self
Name: _____
SS#: _____ Date of Birth:_____
Email: _____ Cell Phone: _____
Employer:_____
Occupation: _____
No. of yrs. employed: ___ Work Phone: _____
Address: (if different from patient)
Street: _____
City: _____ State: ___ Zip:_____
How long at residence: ____ Home Phone: _____
Previous Address: (if less than 3 yrs)
Street: _____
City: _____ State: ___ Zip:_____

Dental Insurance Information

Insured's Name: _____ Insured's SS#:_____
Insurance Company: _____ Group Number: _____
Insurance Co. Address: _____ City: _____ State: ___ Zip:_____
Do you have dual coverage?: Yes ___ No ___
Secondary Insurance Co: _____ Insured: _____
Group #: _____ Policy #: _____ Phone:_____

Emergency Information

Emergency contact not living with you: _____
Complete Address: _____ City: _____ State: ___ Zip: _____
Phone Number: _____ Relationship: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services the patient may need.
This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered and also responsible for paying any insurance co-payment and deductibles that my insurance does not cover. I hereby authorize the

orthodontist to release all information necessary to secure the payment or benefits.

Signature: _____ Date: _____

Medical History

Physician: _____ Phone:_____Date of Last Visit: _____

Please circle yes or no (if yes, please specify)

Yes No Are you taking any medications (including for osteoarthritis)?_____

Yes No Are you allergic to any medications? _____

Yes No Do you have any other allergies? (latex, nickel, metal)_____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any major operations? _____

Yes No Have you ever been involved in a serious accident?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding	Dizziness	High Blood Pressure	Sleep Disorders
ADD/ADHD	Epilepsy	HIV/Aids	Tuberculosis
Anemia	Gastrointestinal	Kidney Problems	Tumor or Cancer
Arthritis	Disorders	Nervous Disorders	Back / Shoulder pain
Asthma	Heart Problems	Pneumonia	Eye or Ear problems
Bone Disorders	Heart Murmur	Prolonged Bleeding	Headaches
Congenital Heart	Hepatitis/Liver	Radiation/Chemo	Osteoarthritis
Defect	problems	Rheumatic Fever	
Diabetes	Herpes	Sleep Apnea	

Yes No Do you require antibiotics prior to any dental treatment?

Yes No Are there any medical conditions that you would like to discuss with the Doctor in private?_____

_____

Dental History

Dentist: _____ Date of Last Visit: _____ Address:

_____ City: _____ State: ___ Zip: _____ Phone:_____

What are your orthodontic concerns?_____

How do you feel about receiving orthodontic treatment?_____

_____

Yes No Has anyone in your family received orthodontic treatment? If yes, how did they feel about the result? _____

_____

Yes No Have you ever seen an orthodontist before? Who and when? _____

Yes No Have you always had a favorable dental experience?

Yes No Are you presently in any dental pain?

Yes No Have you ever had any teeth removed?

Yes No Do you have any congenitally missing teeth?

Yes No Do you have extra teeth?

Yes No Have you ever lost or chipped any teeth?

Yes No Have you had your tonsils or adenoids removed?

Yes No Have there been any injuries to the face, mouth or teeth?_____

Yes No Is any part of your mouth sensitive to temperature or pressure?

Yes No Do your gums bleed when you brush?

Yes No Do you have any thumb or finger sucking habits?

Yes No Do you have a tongue thrust?

Yes No Are you a mouth breather?

Yes No Do you snore?

Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning?

Yes No Are you aware of your jaw clicking or popping?

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?

Yes No Do you have tension headaches?

Females Only:

Yes No Are you pregnant?

Yes No Has menstruation started?

Parent/Guardian Signature: _____ Date: _____

TC Signature: _____ Date: _____ Drs. Signature: _____Date:_____

Review / Update (initial and date): _____ _____ _____ _____ _____