

Hannon•Orthodontics
Specialist for children • teens • adults



welcome!
new patient registration

Today's Date _____

Patient Name _____ Prefers to be called _____

Address _____

City, State, ZIP _____

Home Phone _____ Birthdate _____ Age _____ Sex _____

Who may we contact in case of emergency _____ Phone _____

Email _____

Family Dentist _____ Family Physician _____

What do you wish was different about your smile? _____

Who may we thank for referring you to Hannon Orthodontics? _____

Father's Name _____ Birthdate _____ Phone _____

Occupation _____ Employer _____

Mother's Name _____ Birthdate _____ Phone _____

Occupation _____ Employer _____

Father's work phone _____ Mother's work phone _____

Brothers and Sisters:

Name _____ Birthdate _____ Name _____ Birthdate _____

Name _____ Birthdate _____ Name _____ Birthdate _____

Person responsible for account _____

If divorce is involved, who is the Custodial Parent? _____

May patient information be released to the Noncustodial Parent? NO YES

Address _____

City, State, ZIP _____

Do you have orthodontic insurance coverage? NO YES, Company _____

Insurance Company Address _____

City, State, ZIP _____

Name of Insured _____

Group Number _____ Phone/Contact _____

SS# _____

May we use your photo and comments/quotes in advertising campaigns? YES NO

Signature _____

“Everytime you smile at someone, it is an action of love, a gift to that person, a beautiful thing.”

-Mother Teresa

Health Questionnaire

Today's Date _____

Patient Name _____ Birthdate _____

Family Dentist _____ Date of last dental visit _____

Have you ever had the following dental treatment?

- Orthodontics _____ date _____ by Dr. _____
- Periodontal treatment (gum treatment)
- Mouthguard or splint therapy for jaw joint problems
- Jaw surgery to change your bite or to correct jaw joint

Do you have or have you had any of the following oral conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Food wedging between teeth |
| <input type="checkbox"/> Clenching or grinding | <input type="checkbox"/> Pain around ear | <input type="checkbox"/> Swelling or lumps in the mouth |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Pain in the jaw, face | <input type="checkbox"/> Oral habits (thumb sucking, etc.) | <input type="checkbox"/> Jaw joint sounds or pain |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Pain when opening mouth | <input type="checkbox"/> Inability to floss between teeth |
| <input type="checkbox"/> Poorly functioning teeth | <input type="checkbox"/> Discolored teeth | <input type="checkbox"/> Jaw get stuck open or closed |

Do you have or have you had any of the following medical conditions?

- | | | |
|--|--|--|
| Y/N | Y/N | Y/N |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Congenital heart lesions/murmur | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis, swollen joints |
| <input type="checkbox"/> Inflammatory rheumatism | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Yellow jaundice | <input type="checkbox"/> Hepatitis type _____ |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Convulsions or seizure |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Swallowing problems |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> ADD/AHA | | |

Y/N

- Are you currently under a physician's care? If yes, describe
- Has patient ever been hospitalized or had any serious illness? If yes, describe
- Does patient have any drug allergies? If yes, list medications
- Is patient allergic to latex, metal or vinyl?
- Is patient taking any medication? If yes, list medications
- Female patients - could patient possibly be pregnant at the present time

Patient or Parent Signature (if patient is under 18 years)

_____ Date _____

Notes _____

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