

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 _____



driving directions to gastonia, belmont & shelby



Gastonia Office **525 S. New Hope Rd., Gastonia**

Traveling South I-85 South towards Gastonia. Exit #20 Dallas/New Hope Rd. Turn Left onto N. New Hope Rd. (Hwy 279). Cross over Franklin Blvd. Go approx. 4/10 of a mile. Office is on the right, behind Citizens South Bank.

Traveling North I-85 North towards Gastonia/Charlotte. Exit #20 Dallas/New Hope Rd. Turn right onto N. New Hope Road.(Hwy 279). Cross over Franklin Blvd. Go approx. 4/10 of a mile. Office is on the right, behind Citizens South Bank.



Belmont Office **301 Park St., Belmont**

Traveling South I-85 South towards Gastonia. Exit #27 Belmont/Mt. Holly. Turn left onto Park St.(Hwy 273). Cross over Wilkinson Blvd. Go approx. 1/3 of a mile. Office is on the right.

Traveling North I-85 North towards Charlotte. Exit #27 Mt Holly. Turn right onto Park St. (Hwy 273). Cross over Wilkinson Blvd. Go approx. 1/3 of a mile. Office is on the right.



Shelby Office **221 Simpson Park Rd., Shelby**

Traveling South I-85 South towards Shelby. Exit #10B Kings Mtn./Shelby onto US-74W. Turn right onto E. Marion St. Turn right onto Cherryville Rd. Turn left on Wyke Rd. Turn left onto Simpson Park Rd. Office is on the right, inside Dr. Jimachello's Dentist Office.

"A warm smile
is the
universal
language of
kindness."

-Wm. A.Ward