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 _____ Work Phone _____

Email _____

Occupation _____ Employer _____

Spouse's Name _____ Work Phone _____

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Family Dentist _____ Family Physician _____

What do you wish was different about your smile? _____

_____

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

Person responsible for account _____

SS# _____ Birthdate _____ Age _____ Sex ____

Address _____

City, State, ZIP _____

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

Insurance Company Address _____

City, State, ZIP _____

Name of Insured _____

Group Number _____ Phone/Contact _____

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

Signature _____

"The world always looks better from behind a smile."

-Anonymous

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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?

☐ Sensitive teeth	☐ Bleeding gums	☐ Food wedging between teeth
☐ Clenching or grinding	☐ Pain around ear	☐ Swelling or lumps in the mouth
☐ Bad Breath	☐ Mouth Breathing	☐ Tobacco use
☐ Pain in the jaw, face	☐ Oral habits (thumb sucking, etc.)	☐ Jaw joint sounds or pain
☐ Dry mouth	☐ Pain when opening mouth	☐ Inability to floss between teeth
☐ Poorly functioning teeth	☐ Discolored teeth	☐ 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
☐☐ Rheumatic Fever	☐☐ Congenital heart lesions/murmur	☐☐ Heart condition
☐☐ Diabetes	☐☐ Anemia	☐☐ Arthritis, swollen joints
☐☐ Inflammatory rheumatism	☐☐ Kidney problems	☐☐ Tuberculosis
☐☐ Asthma	☐☐ Yellow jaundice	☐☐ Hepatitis type _____
☐☐ Liver Disease	☐☐ High Blood Pressure	☐☐ Low Blood Pressure
☐☐ Severe headaches	☐☐ Dizziness or fainting	☐☐ Convulsions or seizure
☐☐ Eye problems	☐☐ Ear problems	☐☐ Sinus problems
☐☐ Nose bleeds	☐☐ Speech problems	☐☐ Swallowing problems
☐☐ Easy Bruising	☐☐ Venereal disease	☐☐ HIV positive
☐☐ 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 _____

_____

_____

"Most smiles are started by another smile."

-Anonymous