hebron orthodontics
transforming great smiles for life

NEW PATIENT FORM

PATIENT INFORMATION

First ________________________________ Last _______________________________ Middle Initial _________

Birthdate _____________________________Parent or guardian (for minors) ______________________________

Address ______________________________________ City _______________________ State _____ Zip ________

Cell _____________________________ Home ________________________ Email __________________________

Whom may we thank for referring you to our office? ____

General Dentist _______________________________________ Last Visit _________________________________

Previous orthodontic treatment or evaluated by an orthodontist? ____________________When? ______________

What concerns you most about your teeth? ____

Do you have a preference(s) for: Invisalign / Clear Braces / Self-ligating Brackets

Do you have any special occasion(s) in the future that we need to be aware of (i.e wedding, graduation)?

Occasion(s) ____ When? ____________________________

Would you be interested in accelerated orthodontics using Propel or Acceledent? ___________Yes ___________ No

How motivated are you (or your child) to start treatment? ____

RESPONSIBLE PARTY

Policy Holder's Name________________________ Birthdate ____________ Relationship to Patient ______________

Insurance Company ____ Phone No. _______________________

Insured's SS#/ID# ____ Employer ________________________

INSURANCE VERIFICATION (OFFICE USE ONLY)

Effective Date _______________________ Group No._____________________ Lifetime Max __________________

Paid @ (%) __________________________ Deductible ($) __________________Used to Date ($) ______________

Age limit _____________________________ FT Student ____________________ Adult Coverage _______________

Waiting Period _______________________ Manually / Automatically / Monthly / Quarterly / Semi-Annual/ Annual

Mail Claims To ____

MEDICAL HISTORY

Physician____________________________ Phone ______________________Date of Last Visit______________________
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? ____
Yes No Is the patient allergic to any medication? ____
Yes No History of a major illness? ____
Yes No Has the patient had any operations? ____
Yes No Ever been involved in a serious accident? ____
Yes No Have you seen a physician in the last 12 months? Why? ____
Female Patients only: Has menstruation started? _______ Y_______ N Is the patient pregnant? ________ Y_______ N

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?
____

DENTAL HISTORY

Yes No Is the patient presently in any dental pain? ____
Yes No Ever experienced any unfavorable reaction to dentistry? ____
Yes No Has the patient ever lost or chipped any teeth? ____
Yes No Have there been any injuries to face, mouth, or teeth? ____
Yes No Is any part of your mouth sensitive to temperature? Where? ______________________________________
Yes No Is any part of your mouth sensitive to pressure? Where? ____
Yes No Do gums bleed when brushing? ____
Yes No Any type of thumb or tongue habit? ____
Yes No Is the patient a mouth breather? ____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? ______________________________
Yes No What is the patient’s attitude toward receiving orthodontic treatment? __________________________
Yes No Has anyone in the family received orthodontic treatment? _______________________________________
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? ___________________________
Yes No Experience jaw clicking or popping? ____
Yes No Aware of clenching or grinding teeth during the day? ____
Yes No Experience “tension” headaches? ____
Yes No Has the patient ever experienced chronic ringing in the ears? ______________________________
Yes No Is the patient sensitive or self-conscious about his/her teeth? ______________________________

I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. To to perform a complete orthodontic evaluation.

Signature: ____Date: __________________________