ADULT PATIENT INFORMATION

Last Name _____First Name_____Middle_____

I prefer to be called_____DOB_____/____/____Male/Female Age_____

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

Has our office seen anyone from your family before? Yes / No If yes, who?_____

BILLING INFORMATION (Self___ Spouse___ Parent___)

Last Name_____First Name_____

Address_____Employer_____Occupation_____

City, State, Zip_____DOB_____

Home phone #_____Work phone #_____

Cell phone_____Email_____

SS # /ID #_____Insurance Carrier_____

Group #_____Phone # _____

Orthodontic Coverage? Yes/ No ***If Yes, have any past claims been file ? Yes / No***

SECONDARY BILLING INFORMATION (Self___ Spouse___ Parent___)

Last Name_____First Name_____

Address_____Employer_____Occupation_____

City, State, Zip_____DOB_____

Home phone #_____ Work phone #_____

Cell phone_____Email_____

SS # /ID #_____Insurance Carrier_____

Group #_____Phone # _____

Orthodontic Coverage? Yes/ No ***If Yes, have any past claims been file ? Yes / No***

I HEREBY AUTHORIZE INSURANCE PAYMENT DIRECTLY TO DR. WAYNE S. HANE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY DENTAL INSURANCE. I AUTHORIZE RELEASE OF ANY INFORMATION PERTAINING TO MY DENTAL CLAIM.

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. 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 questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Hane to perform a complete orthodontic evaluation.

I acknowledge that I have received the “Notice of Privacy Practices” for Wayne S. Hane DDS Initial_____

Signature:_____Date:_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
Address _____ Phone # _____
What concerns you most about your teeth? _____
_____

Please circle Yes or No (If Yes, please fill in details).

Yes	No	Have you had previous orthodontic consultation or treatment? When?_____
Yes	No	Do you have any difficulty chewing or swallowing?
Yes	No	Have any family members had orthodontic treatment? Who? _____
Yes	No	Are you aware of any tooth grinding or clenching?
Yes	No	Do you have pain or clicking of the jaw joint?
Yes	No	Have you ever had a severe head or jaw injury?
Yes	No	Do your gums bleed on brushing or flossing?
Yes	No	Have you had any permanent teeth extracted?
Yes	No	Do you experience “tension” headaches more than once a week?
Yes	No	Have you ever experienced any unfavorable reaction to dentistry?
Yes	No	Are there any other dental/orthodontic problems I should be aware of?

MEDICAL HISTORY

Physician _____ Date of Last Visit_____
Address _____ Phone _____

Yes	No	Are you taking any medication? _____
Yes	No	Are you allergic to any medication? _____
Yes	No	Do you have a history of a major illness? _____
Yes	No	Have you had any operations? _____
Yes	No	Have you ever been involved in a serious accident? _____
Yes	No	Have you ever smoked or chewed tobacco? _____
Yes	No	Have seen a physician in the last 12 months? Why? _____
		Female Patients only:
Yes	No	Are you pregnant?

Please CIRLCE EACH Yes or No for each individual medical condition:

Yes	No	Abnormal bleeding/Hemophilia	Yes	No	Heart Problems
Yes	No	ADD/ADHD	Yes	No	Hepatitis/Liver problems
Yes	No	Allergies	Yes	No	Herpes
Yes	No	Anemia	Yes	No	High Blood Pressure
Yes	No	Arthritis	Yes	No	HIV / Aids
Yes	No	Artificial Bones/Joints	Yes	No	Kidney problems
Yes	No	Asthma or Hay fever	Yes	No	Nervous Disorders
Yes	No	Autism/Cerebral Palsy/Down’s syndrome	Yes	No	Pneumonia
Yes	No	Bone Disorders	Yes	No	Prolonged Bleeding
Yes	No	Congenital heart Defect	Yes	No	Psychiatric problems
Yes	No	Diabetes	Yes	No	Radiation/Chemotherapy
Yes	No	Dizziness	Yes	No	Rheumatic Fever
Yes	No	Epilepsy	Yes	No	Tuberculosis
Yes	No	Gastrointestinal Disorders	Yes	No	Tumor or Cancer
Yes	No	Are Antibiotics required prior to dental treatment?			

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

Patient’s signature_____Date_____