PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Last Name ______________________________First Name______________________________

I prefer to be called _____________________DOB_______/________/_________ Male/Female Age____

School ___________________ Grade __________Hobby/Sport___________________________________

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

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

Father's information (STEPFATHER____GUARDIAN____PARENT____)

Last Name ___________________First Name______________________Occupation__________________

Address_______________________________________Employer_________________________________

City, State, Zip______________________________ DOB____

Home Phone# ____________________ Cell# _________________ Work Phone # __________________

Insurance Carrier_____________________________Group______________Phone___________________

Address ____City, State, Zip___________________

Orthodontic coverage? YES / NO If YES, Have any past claims been filed? YES / NO

Mother's information (STEPMOTHER_____GUARDIAN_____PARENT____)

Last Name ____________________First Name_______________________Occupation_______________

Address______________________________Employer____

City, State, Zip______________________________ DOB____

Home Phone# ____________________ Cell# _________________ Work Phone # __________________

Insurance Carrier_____________________________Group______________Phone___________________

Address ____City, State, Zip___________________

Orthodontic coverage? YES / NO If YES, Have any past claims been filed? 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. Wayne 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 is the major concern about the patient's teeth? ____
____

Yes	No	Has the patient had previous orthodontic consultation or treatment? When?__________
Yes	No	Has the patient been informed of any extra or missing teeth?
Yes	No	Have any family members had orthodontic treatment? Who?_______________________
Yes	No	Does the patient now suck the thumb or fingers?
Yes	No	Does the patient predominately breath through the mouth or have any type of tongue habit?
Yes	No	Does the patient have any speech problems?
Yes	No	Does the patient grind or clench the teeth?
Yes	No	Does the patient have pain or clicking of the jaw joint?
Yes	No	Have any teeth been injured due to an accident?
Yes	No	Has the patient ever had a severe head or jaw injury?
Yes	No	Does the patient experience "tension" headaches?
Yes	No	Does the patient need extra help with instructions?
Yes	No	Does the patient's gums bleed on brushing or flossing?
Yes	No	Is the patient sensitive or self-conscious about his/her teeth?
Yes	No	Are there any other dental/orthodontic problems I should be aware of?
Yes	No	Height of parents? Mom______ Dad______
Yes	No	Are you aware that some appointments will be during school hours?

MEDICAL HISTORY

Physician ____ Date of Last Visit ___________________
Address ____ Phone# ____________________________

Please CIRCLE EACH 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 seen a physician in the last 12 months? Why?____________________________
Yes	No	Has the patient had tonsils and/or adenoids removed?
		Female Patients only:
Yes	No	Has menstruation started?
Yes	No	Is the patient pregnant?

Please CIRCLE EACH Yes or No for the individual medical conditions:

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?

Parent's Signature____Date________________