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 snore or have sleep apnea?
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_____