

PATIENT INFORMATION											
PATIENT NAME (FIRST, MI, LAST) <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> DR						SEX <input type="checkbox"/> M <input type="checkbox"/> F		TODAY'S DATE / /			
MAILING ADDRESS					CITY			STATE		ZIP CODE	
DATE OF BIRTH / /		SOCIAL SECURITY #			HOME PHONE #			WORK PHONE # (EXTENSION)			
AGE	GRADE	SCHOOL		IF A MINOR, PARENT/ GUARDIAN NAME				CELL PHONE #			
PLEASE LIST YOUR ORTHODONTIC CONCERNS FOR PATIENT:					OTHER CHILDREN AND AGES: (DID THEY HAVE BRACES?)						
WHOM CAN WE THANK FOR REFERRING YOU? (PLEASE FILL OUT)					WHERE DID YOU SEE OUR NAME OR LOGO? (PLEASE FILL OUT)						
EMAIL ADDRESS (FOR COMMUNICATION, APPOINTMENTS, ETC)											
PRIMARY RESPONSIBLE PARTY INFORMATION											
NAME (FIRST, MI, LAST) <input type="checkbox"/> SAME AS ABOVE <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> DR								RELATIONSHIP TO PATIENT			
BILLING ADDRESS <input type="checkbox"/> SAME AS ABOVE					CITY			STATE		ZIP CODE	
DATE OF BIRTH / /		SOCIAL SECURITY # (MUST COMPLETE)			HOME PHONE #			WORK PHONE # (EXTENSION)			
ORTHODONTIC COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW			EMPLOYER NAME (MUST COMPLETE)				GROUP ID # (MUST COMPLETE)				
DENTAL INSURANCE NAME		IN	INSURANCE PHONE #		LIFETIME MAX	%	DEDUCTIBLE		PAYOUT	AGE	USED
		OUT									
DENTAL INSURANCE ADDRESS					CITY			STATE		ZIP CODE	
SECONDARY RESPONSIBLE PARTY INFORMATION											
NAME (FIRST, MI, LAST) <input type="checkbox"/> SAME AS ABOVE <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> DR								RELATIONSHIP TO PATIENT			
BILLING ADDRESS <input type="checkbox"/> SAME AS ABOVE					CITY			STATE		ZIP CODE	
DATE OF BIRTH / /		SOCIAL SECURITY # (MUST COMPLETE)			HOME PHONE #			WORK PHONE # (EXTENSION)			
ORTHODONTIC COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW			EMPLOYER NAME (MUST COMPLETE)				GROUP ID # (MUST COMPLETE)				
DENTAL INSURANCE NAME		IN	INSURANCE PHONE #		LIFETIME MAX	%	DEDUCTIBLE		PAYOUT	AGE	USED
		OUT									
DENTAL INSURANCE ADDRESS					CITY			STATE		ZIP CODE	
SIGNATURE MUST BE COMPLETE											
I AM AWARE THAT I, NOT MY INSURANCE COMPANY, AM RESPONSIBLE FOR THIS ENTIRE ACCOUNT ALTHOUGH THE INSURANCE COMPANY MAY PAY A PORTION OF THE FEE CHARGED. I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR DENTAL SERVICES AND MATERIALS NOT PAID BY MY DENTAL BENEFIT PLAN, UNLESS THE TREATING DENTIST/ORTHODONTIST OR DENTAL PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO HENDRIX ORTHODONTICS, P.C., HENDRIX ORTHODONTICS CHESTER COUNTY, P.C. OR JEFFREY M. HENDRIX, DDS, MS. TO THE EXTENT PERMITTED UNDER APPLICABLE LAW, I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.											
SIGNATURE OF EMPLOYEE/SUBSCRIBER						DATE (MM/DD/YYYY)					

**DENTAL HISTORY**

Dentist's Name:								
Dentist's Address:								
Dentist's Phone #								
<b>X</b>	<b>PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:</b>							
	Chipped or otherwise injured teeth	Has patient ever had a prior orthodontic exam or treatment?				Y	N	
	History of speech problems	Orthodontist Name & Treatment:						
	Abnormal swallowing habit (tongue thrusting)	Is this a 2nd opinion?				Y	N	
	Teeth sensitive to hot or cold; teeth throb or ache	<b>X</b>	<b>CONCERNS:</b>		<b>X</b>	<b>CONCERNS:</b>		
	Jaw fractures, cysts, mouth infections		Price			Insurance/Flex		
	Root canal treatment or "Dead Teeth"		Treatment Options			Treatment Necessity		
	Bleeding gums, Periodontal disease, or "Gum Problems"		Timing of Treatment			Office Location/Proximity		
	Cold sores, frequent canker sores, or "Gum Boils"		Other (please list):					
	Mouth breathing habit, snoring, or difficulty breathing							
	Tooth grinding, jaw clenching, clicking, or locking	Would the patient object to wearing braces?				Y	N	
	Pain or soreness in the jaw or muscles of the face	Is patient taking any form of fluoride?				Y	N	
	Treatment for "TMJ" problems or facial muscle pain	How often does patient brush?		Floss?				
	Difficulty encountered in chewing or jaw opening	Family history of jaw problems or surgery?						
	History of "extra" or congenitally missing teeth	Onset of puberty/menarche (Adolescent Patients Only) :						
	Removal of any permanent teeth? Baby teeth? (circle)	Female Patients Only (For X-Ray Concerns):						
	Any loose, broken, or missing restorations (fillings)					Are you pregnant?	Y	N
	Has patient ever had periodontal (gum) treatment?					Are you taking birth control pills?	Y	N
	Thumb or finger-sucking habit? Until:					Anticipating becoming pregnant?	Y	N

**MEDICAL HISTORY**

Please list ALL current medications and supplements:

Is patient allergic to any medications? Other allergies? List:

List other conditions that we should be aware of to better treat the patient?

<b>X</b>	<b>PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:</b>					<b>X</b>	<b>PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:</b>					
	Heart murmur- If so, do you take antibiotics?	Y	N				ADD, ADHD, OCD, ASD, ODD, Asperger's (circle)					
	Rheumatic fever, heart problem, pacemaker							Asthma, hay fever, sinus trouble, hives				
	Nickel or latex allergy? (circle)							Behavioral or mental health disorder				
	Recovering addict? How long have you been in recovery?							High or low blood pressure				
	Bone fractures or any major accidents							Fainting, seizures, epilepsy, or neurological problem				
	Tonsil or adenoid conditions? Removed?	Y	N				Drug, alcohol, or substance abuse past or present					
	Diabetes, endocrine, thyroid, or kidney problems							Problems of the immune system				
	Cancer, tumor, or radiation treatment							AIDS or HIV positive				
	Hepatitis, jaundice, or liver problem							Frequent headaches, colds, or sore throats (circle)				
	Tuberculosis, mononucleosis, polio, or pneumonia							Rheumatoid or arthritic conditions				

**SIGNATURE MUST BE COMPLETE**

I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL AND DENTAL QUESTIONNAIRE. I WILL NOT HOLD MY ORTHODONTIST OR ANY OTHER MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM. IF THERE ARE ANY CHANGES LATER TO THE HISTORY RECORD OR MEDICAL AND DENTAL STATUS, I WILL SO INFORM THE PRACTICE.

<b>SIGNATURE OF PATIENT/PARENT/GUARDIAN</b>	<b>DATE (MM/DD/YYYY)</b>
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