PATIENT INFORMATION

PATIENT NAME (FIRST, MI, LAST) □ MR □ MRS □ MS □ MISS □ DR	SEX □ M □ F	TODAY'S DATE / /

MAILING ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH / /	SOCIAL SECURITY #	HOME PHONE #	CELL PHONE #

AGE	GRADE	SCHOOL	IF A MINOR, PARENT/ GUARDIAN NAME	WORK PHONE # (EXTENSION)

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 APPOINTMENT REMINDERS, CORRESPONDENCE, ETC.)

PRIMARY RESPONSIBLE PARTY INFORMATION

NAME (FIRST, MI, LAST) □ SAME AS ABOVE □ MR □ MRS □ MS □ MISS □ DR	DATE OF BIRTH / /	RELATIONSHIP TO PATIENT

BILLING ADDRESS □ SAME AS ABOVE	CITY	STATE	ZIP CODE

SOCIAL SECURITY # (MUST COMPLETE)	HOME PHONE #	CELL PHONE #	WORK PHONE # (EXTENSION)

ORTHODONTIC COVERAGE? □ YES □ NO □ DON'T KNOW	EMPLOYER NAME (MUST COMPLETE)	GROUP ID # (MUST COMPLETE)

DENTAL INSURANCE NAME	IN OUT	INSURANCE PHONE #	LIFETIME MAX	%	DEDUCTIBLE	PAYOUT	AGE	USED

DENTAL INSURANCE ADDRESS	CITY	STATE	ZIP CODE

SECONDARY RESPONSIBLE PARTY INFORMATION

NAME (FIRST, MI, LAST) □ SAME AS ABOVE □ MR □ MRS □ MS □ MISS □ DR	DATE OF BIRTH / /	RELATIONSHIP TO PATIENT

BILLING ADDRESS □ SAME AS ABOVE	CITY	STATE	ZIP CODE

SOCIAL SECURITY # (MUST COMPLETE)	HOME PHONE #	CELL PHONE #	WORK PHONE # (EXTENSION)

ORTHODONTIC COVERAGE? □ YES □ NO □ DON'T KNOW	EMPLOYER NAME (MUST COMPLETE)	GROUP ID # (MUST COMPLETE)

DENTAL INSURANCE NAME	IN OUT	INSURANCE PHONE #	LIFETIME MAX	%	DEDUCTIBLE	PAYOUT	AGE	USED

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. I AUTHORIZE COMMUNICATION VIA PHONE, TEXT, & EMAIL FOR APPOINTMENT REMINDERS, CORRESPONDENCE, ETC.

SIGNATURE OF EMPLOYEE/SUBSCRIBER	**DATE (MM/DD/YYYY)**

DENTAL HISTORY

Dentist's Name:	
Dentist's Address:	
Dentist's Phone #	

X	PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:					
	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? (Select Yes or No)			Y	N
	Teeth sensitive to hot or cold; teeth throb or ache	**X**	**CONCERNS:**	**X**	**CONCERNS:**	
	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?

X	PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:				X	PLEASE X IF PATIENT HAS OR HAS HAD ANY BELOW:
	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 OMISSSIONS THAT I HAVE MADE IN THE COLPLETION OF THIS FORM. IF THERE ARE ANY CHANGES LATER TO THE HISTORY RECORD OR MEDICAL AND DENTAL STATUS, I WILL SO INFORM THE PRACTICE.

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