

Welcome To Hatala Orthodontics

Please fill out this form as completely as possible prior to your child's
Initial Orthodontic Examination Appointment **Thank You!**
(Please Print)

About Your Child		Today's Date _____	
Child's Name _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	
He / She prefers to be called _____		Birth-date ____/____/____ Age _____	
Home Address _____		Apt. # _____	
_____		_____	
Home # _____		Cell / Other # _____ E-Mail _____	
School _____ Grade _____		Hobbies / Sports _____ How did you hear about our office? _____	
List names and ages of brothers / sisters _____			
Who is accompanying your child today? Name _____ Relation _____			
Person Responsible for making appointments: Name _____ Home # _____ Work # _____			
Parent's Information		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Who has primary custody? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
Mother's Name _____		<input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian	
Home # _____		Cell / Other # _____ E-Mail _____	
Soc. Sec. # _____		Birth-date ____/____/____ Years employed at current job _____	
Employer _____		Job Title _____ Work # _____ Ext _____	
Father's Name _____		<input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian	
Home # _____		Cell / Other # _____ E-Mail _____	
Soc. Sec. # _____		Birth-date ____/____/____ Years employed at current job _____	
Employer _____		Job Title _____ Work # _____ Ext _____	
Person Responsible for Account		His/Her Name _____ Relationship _____	
Address (if different from above) _____			
Home # _____		Cell / Other # _____ E-Mail _____	
Soc. Sec. # _____		Birth-date ____/____/____ Years employed at current job _____	
Employer _____		Job Title _____ Work # _____ Ext _____	
Orthodontic Insurance		Primary Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insured _____		Relationship _____	
Insurance Company Name _____		Phone # _____	
Insurance Company Address _____		ID # _____	
Secondary Orthodontic Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Insured _____		Relationship _____	
Insurance Company Name _____		Phone # _____	
Insurance Company Address _____		ID # _____	
Dental Care Information		Dentist's Name _____ Date of Last Visit _____	
What is your primary concern about your child's teeth? _____			
Have you had other Orthodontic consultations / treatment? _____ Orthodontist _____			
Patient's attitude toward orthodontic treatment: <input type="checkbox"/> Very motivated <input type="checkbox"/> Will cooperate if needed <input type="checkbox"/> Not motivated			

Dental Information

Your child's current Dental health is Good Fair Poor

Your child brushes / flosses everyday? Yes No

Has your child had or noticed any of the following? (check if "Yes")

- | | |
|--|--|
| <input type="checkbox"/> Traumatic injury to Teeth, Mouth or Chin (Please Circle) | <input type="checkbox"/> Pain, swelling, or bleeding of gums |
| <input type="checkbox"/> Pain or tenderness around ear, joint, or side of face (TMJ / TMD) | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Teeth sensitive to hot, cold, or pressure | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Missing or extra permanent teeth | <input type="checkbox"/> Breathes through mouth |
| <input type="checkbox"/> Clenching / Grinding Teeth | <input type="checkbox"/> Nursing Bottle Habits |
| <input type="checkbox"/> Thumb / Finger sucking | <input type="checkbox"/> Lip Sucking / Biting |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Tongue Thrust |
| <input type="checkbox"/> Ever taken Phen-Fen? (Also known as Redux or Pondimin). When? _____ | |

If Yes, please explain _____

List any musical instruments played: _____

Medical Information

Your child's current Physical health is Good Fair Poor

Physician's Name _____ Date of Last Visit ___/___/___ Phone # _____

Is your child under a Physician's care? For what reason? _____

Please list all medications your child is currently taking: _____

Does your child require any medications prior to dental work? _____

Has your child ever had any of the following? (check if "Yes")

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Handicaps / Disabilities | <input type="checkbox"/> HIV+ / AIDS |
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Any Operations | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Bones / Joints / Valves | <input type="checkbox"/> Epilepsy / Fainting / Seizures | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growth Disorders | <input type="checkbox"/> Hepatitis / Liver problems | <input type="checkbox"/> Tuberculosis (TB) |

Please discuss any medical conditions / problems your child has had: _____

Has puberty begun? Yes No

Female patients: Has menstrual cycle started? Yes No

Does your child have Allergies to any of the following? (check if "Yes")

- | | | | |
|--|---|--------------------------------|--|
| <input type="checkbox"/> Any Medications | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Metals / Plastics |
|--|---|--------------------------------|--|

Please list all of your child's allergies: _____

Emergency Information

Name of neighbor or relative not living with you _____

Home # _____ Cell / Other # _____ Relationship _____

Address _____

Please bring this completed form to your child's Initial Orthodontic Exam Appointment.

We look forward to meeting you!

The information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform Hatala Orthodontics of any changes to this information.

I authorize the dental staff of Hatala Orthodontics to perform any dental services my child may need.

Signature of parent or guardian _____ Date _____

This Office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

Signature of parent or guardian _____ Date _____

OFFICE USE ONLY

I have verbally reviewed the Medical and Dental information above with the parent / guardian and patient.

Initials _____ Date _____ Doctor's Comments: _____

Thank you for filling out this form!