Welcome to Haack Orthodontic Clinic.

Thank you for providing this important information and filling out this form in advance.

Today's Date:___/___/___

ABOUT YOU:

Your Name:____ Nickname:________________________

What are the main concerns that you would like orthodontics to accomplish?____________________

____

Age:_______ Date of Birth:_____/_____/_____ {Male {Female

Home Address:____

____

Home phone #: (_____)______-___________ Work phone #: (_____)______-_____________

E-mail address:_______________________________Employer:_________________________________

Hobbies/Sports/Musical Instruments played?:____

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

Your General Dentist:____

Approximate Date of Last Visit to General Dentist:_____/_____/_____

Marital Status: {Married {Divorced {Separated {Single {Widowed

Spouse Name (if applicable):____

Spouse's employer and work phone number:____

Other Emergency Contact Person
(name, relationship, phone numbers):____

INSURANCE INFORMATION:

Primary Insurance:

Dental Coverage? {Yes {No {Not Sure Orthodontic Coverage? {Yes {No {Not Sure

Insurance Company Name:____

Policy Owner's Name:____

Relationship to Patient:____

Policy Owner's Birthdate:_____/_____/_____ Soc. Sec. #:____________________________

Policy Owner's Employer:____

Secondary Insurance:

Dental Coverage? {Yes {No {Not Sure Orthodontic Coverage? {Yes {No {Not Sure

Insurance Company Name:____

Policy Owner's Name:____

Relationship to Patient:____

Policy Owner's Birthdate:_____/_____/_____ Soc. Sec. #:____________________________

Policy Owner's Employer:____

YOUR HEALTH HISTORY AND STATUS:

Have there been any injuries to the face, mouth, teeth, or chin? ..………… {Yes {No

Do you know if you have any missing or extra teeth? ……………………..… {Yes {No

Have you ever had any pain/tenderness in the jaw joint (TMJ) area? ..…..… {Yes {No

Do you clench or grind you teeth? ………………………………………… {Yes {No

Have you had or do you have a thumb or finger sucking habit? …………...{Yes {No

Please briefly explain any dental concerns above that were checked "yes":______________________

____

____

Please list all drugs that you are currently taking:____

____

Please list all drugs and other things you are allergic to:___________________________________

____

Your Physician:____

Approximate date of last visit to physician:______/______/______

Are you currently under the care of a physician for a specific condition or problem? {Yes {No

<u>Please circle any of the following medical concerns that you have ever had:</u>

Abnormal Bleeding	Heart Surgery
ADD / ADHD	Heart Murmur
Allergic to any Drugs	Congenital Heart Defect
Allergic to Latex, Metals, or Plastic	Hemophilia
Anemia/Radiation Treatment	Hepatitis
Arthritis	High or Low Blood Pressure
Artificial Bones, Joints, or Valves	HIV+ or AIDS
Asthma	Kidney or Liver Problems
Blood Transfusion	Lupus
Cancer/Chemotherapy	Psychiatric Problems
Convulsions or Epilepsy	Recent Hospital Stays
Diabetes	Recent Operations
Drug/Alcohol Abuse	Rheumatic or Scarlet Fever
Handicaps or Disabilities	Sickle Cell Disease or Traits
Severe/Frequent Headaches	Tuberculosis (TB)
Hearing Impairment	Ulcers/Colitis
Heart Attack or Stroke	None of the above

Please briefly explain any positive medical concerns above and any others not listed above:_________

____

____

I UNDERSTAND THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

_______________________________________ _______________

Signature Date

This office reserves the right to verify the 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.

Doctor's Comments and Review:____

____

____