Hattiesburg Orthodontics

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Ste #20
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601•450•2141
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MEDICAL HISTORY

Please circle if patient has or has a history of:

Yes No	Joint swelling	Yes No	Tuberculosis
Yes No	Bone disorders	Yes No	Anemia
Yes No	Heart trouble	Yes No	Epilepsy
Yes No	Mitral Valve Prolapse	Yes No	Prolonged bleeding
Yes No	Rheumatic trouble	Yes No	Faintness/Dizziness
Yes No	Thyroid problems	Yes No	Tonsils removed
Yes No	Diabetes	Yes No	Adenoids removed
Yes No	Emotional problems	Yes No	Sore throats
Yes No	Brain injury	Yes No	Tonsillitis
Yes No	Kidney/ liver problems	Yes No	Earaches
Yes No	Joint Prosthesis	Yes No	Arthritis

On items circled "Yes," please provide us with a more detailed description:

Have you or a member of your family or close family had:
Rheumatoid arthritis? [ ] Yes [ ] No Lupus? [ ] Yes [ ] No

DENTAL HISTORY

Please circle Yes or No:

Yes No Any injuries to face, mouth, teeth?
Yes No Thumb, finger, lip sucking?
Yes No More than average amount of decay?
Yes No Born with any missing permanent teeth?
Yes No Born with any extra permanent teeth?
Yes No Have any teeth ever been pulled?
Yes No Any difficulty swallowing or chewing?
Yes No Any pain or clicking when opening mouth?
Yes No Is patient adopted? At what age? _____
Yes No Does patient visit dentist regularly? Date of last visit_____
Yes No Has an orthodontist been consulted previously?

Reason:

Approximately how much has the patient grown in the last year?

What would you like to have orthodontic treatment accomplish?

List any other serious illnesses:

List any allergies:

List drugs or medications now being taken:

Is patient currently under physician's care?
Reason:

Name of physician:
Primary: Other:

Patient's attitude toward orthodontic treatment:
(circle one) Very motivated Will cooperate if needed Not motivated

Adolescent Females: Has menstruation begun? [ ] Yes [ ] No
Date (month/ year)

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek any reimbursement from the other parent. To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Date

Signature of Patient or Parent or Guardian if Patient is a Minor

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DATE:_____ NO._____

PLEASE PRINT IN INK

PATIENT INFORMATION

LAST NAME	FIRST NAME	NICKNAME	S.S. NO.	SEX	BIRTH DATE	AGE

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE

SCHOOL (if student)	GRADE	[ ] SINGLE [ ] MARRIED [ ] SEP [ ] DIVORCED [ ] WIDOW(ER)	EMPLOYED BY / OCCUPATION	BUSINESS PHONE

EMAIL	FAX	CELL PHONE

WHO MAY WE THANK FOR RECOMMENDING US?	NAME OF DENTIST	DATE OF LAST VISIT

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE	NAMES AND AGES OF OTHER CHILDREN
1	1
2	2

PARENT INFORMATION (please complete if patient is a minor)

FATHER'S NAME _____

ADDRESS (if different from patient's) _____

_____

CITY _____ ST _____ ZIP _____

HOME PHONE _____ BUS. PHONE _____

CELL PHONE _____ FAX _____

S.S. NO. _____ EMAIL _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP_____

MOTHER'S NAME _____

ADDRESS (if different from patient's) _____

_____

CITY _____ ST _____ ZIP _____

HOME PHONE _____ BUS. PHONE _____

CELL PHONE _____ FAX _____

S.S. NO. _____ EMAIL _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP_____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME	RELATIONSHIP TO PATIENT	EMPLOYED BY / OCCUPATION

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	BUSINESS PHONE	CELL PHONE	FAX	EMAIL

IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT?	MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT? [ ] YES [ ] NO