

HARTMAN ORTHODONTICS

Patient #			Exam Date		
PATIENT INFORMATION					
Patient's Last Name		First	Middle	Home Phone	
Address			Birth date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
City		State		ZIP Code	
Dentist		Whom may we thank for referring you to our office?			
<i>If Patient is under 18 years of age please fill out the following questions.</i>					
Parent's or Guardian's Names			School		
What are names and ages of siblings in household					
RESPONSIBLE PARTY INFORMATION					
Last Name		First	Middle	Marital Status	
Physical Address:					
Mailing Address:					
How long at this address?			Home Phone	Work Phone	Cell Phone
Previous Address (if less than 3 years)					
Primary Email			Secondary Email		
Social Security Number			Relationship to Patient		
Employer		Occupation		Years Employed	
Spouse's Last Name		First	Middle	Relationship to Patient	
Employer		Occupation		Years Employed	
Social Security Number		Home Phone		Work Phone	Cell Phone
INSURANCE INFORMATION					
Subscriber's Name			Primary Insurance I.D. Number		
Primary Insurance Company			Group Number		Subscriber's Date of Birth
Primary Insurance Company Address					
Primary Insured's Employer			Primary Insurance Company Phone Number		
Subscriber's Name			Secondary Insurance I.D. Number		
Secondary Insurance Company			Group Number		Subscriber's Date of Birth
Secondary Insurance Company Address					
Secondary Insured's Employer			Secondary Insurance Company Phone Number		
CERTIFICATION OF ACCURACY					
The above information is true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained. I authorize my insurance benefits be paid directly to Dr. Hartman. I understand that I am financially responsible for any balance. I also authorize Dr. Hartman's Office or insurance company to release any information required to process my claims.					
Patient/Guardian Signature				Date	

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Health Questionnaire

Please answer each question regarding the patient. Check Yes or No where applicable.

DENTAL HISTORY			
Physician		Oral Surgeon	
1. Date of last dental examination?		YES	NO
2. Is dental work complete?		<input type="checkbox"/>	<input type="checkbox"/>
3. How often do you brush your teeth?	Floss?		
4. Have you ever had an injury to your face or jaw?		<input type="checkbox"/>	<input type="checkbox"/>
5. Are you aware of tooth grinding or clenching habits?		<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have speech problems?		<input type="checkbox"/>	<input type="checkbox"/>
7. Do you breathe mostly through your mouth?		<input type="checkbox"/>	<input type="checkbox"/>
8. Does orthodontic/dental treatment make you nervous?		<input type="checkbox"/>	<input type="checkbox"/>
9. Does your jaw make a "clicking" or "popping" sound when you chew?		<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever sucked a thumb or finger? Until what age?			
MEDICAL HISTORY			
Are you in good health?		<input type="checkbox"/>	<input type="checkbox"/>
1. Are you presently under the care of a physician?		<input type="checkbox"/>	<input type="checkbox"/>
If so, what is the condition being treated?			
2. Have you ever had any serious illnesses or operation?		<input type="checkbox"/>	<input type="checkbox"/>
If so, please list			
3. Are you taking any drugs or medication?		<input type="checkbox"/>	<input type="checkbox"/>
If so, please list			
4. Are you sensitive or allergic to any drugs?		<input type="checkbox"/>	<input type="checkbox"/>
If so, please list			
5. For minors, has the patient reached puberty?		<input type="checkbox"/>	<input type="checkbox"/>
Menstruated at Age	Voice Changed at Age		
Height	Weight		
6. Do you have a tendency to colds, sore throats, or ear infections?		<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had your tonsils or adenoids removed?		<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been exposed to or tested positive to HIV?		<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have, or have you had any of the following?		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Diseases	<input type="checkbox"/> Rheumatism or Arthritis	
<input type="checkbox"/> Heart Ailments	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Ulcers	
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Tumors or Growths	<input type="checkbox"/> Difficulty in Swallowing	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Radiation Treatment of any kind	<input type="checkbox"/> Venereal Disease	
<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Allergies	<input type="checkbox"/> Acquired Immune Deficiency	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma or Hay Fever	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Fainting Spells or Seizures	<input type="checkbox"/> Mental Disorders	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Artificial Prosthesis (Implants)	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Herpes	<input type="checkbox"/> Sinus Trouble	
10. Do you have any disease, condition or problem not listed?		<input type="checkbox"/>	<input type="checkbox"/>
If so, please list			
IN CASE OF EMERGENCY			
Name of nearest relative not living with you		Relationship to Patient	
Complete Address		Home Phone	Cell Phone