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American Association of Orthodontists



Patient Information

Diplomate, American Board of Orthodontics

Date: _____

Last Name: _____ First Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred Contact Phone: _____

Birthdate: _____ Age: _____ Sex: M F

Dentist: _____ Physician: _____

Has any member of your family been a patient of this office before? Yes No

Name(s): _____

Who may we thank for recommending our office to you? _____

Employed By: _____ Business Phone: _____

Business Address: _____

Marital Status: Single Married Separated Divorced Widowed

Responsible Party (If other than patient)

Person Responsible for account: _____

Relationship to Patient: _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred Contact Phone: _____

Employed By: _____ Business Phone: _____

Business Address: _____

Orthodontic Insurance: Yes No (if "Yes", fill out form provided)

(OVER)

Medical History

Please check any of the following for which the patient has been treated:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Involvement |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Auto-Immune Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Vision/Eye Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Adenoids/Tonsils Removed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Stomach/Digestive Disorders |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Endocrine/Hormonal Problems | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | |

List any other serious illnesses or medical problems _____

Are you presently under the care of a physician? Yes No
If yes, please specify conditions _____

List **ALL** Allergies (including those to any drugs, medications, or **METALS**) _____

List any drugs/medications now taken _____

Do you require antibiotics before dental appointments? Yes No

Dental History

Date of last dental appointment: _____ Were X-rays taken? Yes No

Have you been informed of any missing or impacted teeth? Yes No

Have your wisdom teeth been extracted? Yes No

Do your gums bleed upon brushing or flossing? Yes No

Are you currently seeing a periodontist? Yes No
If so, whom? _____

Have there been any injuries to the face, mouth or teeth? Yes No

Do you have pain, popping or clicking upon opening and closing the mouth? Yes No

Have you ever had splint therapy or worn a night guard? Yes No
Prescribed by whom? _____

Have you had any previous orthodontic consultation or treatment? Yes No
With whom? _____

What would you like to have orthodontic treatment accomplish? _____

A credit history may be obtained in order to make financial arrangements.

Patient Signature Date