



Hatcher Orthodontics

William R. Hatcher, D.D.S., M.S., P.C.
Diplomate, American Board of Orthodontics
Thomas D. Hawley, D.D.S., M.S.
Diplomate, American Board of Orthodontics

American Association
Orthodontists



Patient Information

Date: _____

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

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

Home Phone: _____ Birthdate: _____ Age: _____ Sex: M F

Person w/patient today and relationship: _____

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? _____

Brothers/Sisters (names and ages): _____

Hobbies, sports and other extra curricular activities: _____

Family Information

Father

Mother

Name _____

Address _____

Home / Cell Phone _____ / _____

Occupation _____

Employer _____

Pref. Contact Phone _____

E-Mail Address: _____

Family Marital Status: Single Married Separated Divorced Widowed

Responsible Party

Person Responsible for account: _____

Relationship to Patient: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

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

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"/> Epilepsy | <input type="checkbox"/> Liver or Kidney Problems |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Auto-Immune Disease | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Adenoids Removed:Year _____ |
| <input type="checkbox"/> Vision/Eye Problems | <input type="checkbox"/> Endocrine Disorders | <input type="checkbox"/> Tonsils Removed:Year _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach Disorders |

List any other serious illnesses or medical problems _____

Is the patient 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 _____

Does the patient require antibiotics before dental appointments? Yes No

Dental History

- | | Yes | No |
|---|--------------------------|--------------------------|
| Has the patient ever sucked a thumb or fingers? Until what age? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the patient have any speech problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the patient clench or grind the teeth at night? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the patient have pain, popping or clicking upon opening and closing the mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any teeth been injured or chipped due to accidents? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been informed of any missing permanent teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been informed of any impacted teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Were any permanent teeth removed by extraction? | <input type="checkbox"/> | <input type="checkbox"/> |
| How many times a year does the dentist examine the patient's teeth? _____
Date of last appointment _____ | | |
| Has the patient had a previous orthodontic consultation or treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| With Whom? _____ | | |
| Is the patient concerned about the appearance of his/her teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the patient reached puberty (girls menstruation/boys voice change)? | <input type="checkbox"/> | <input type="checkbox"/> |

What would you like to have orthodontic treatment accomplish? _____

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

 Parent or Guardian Signature