Today's Date: ______________

HALL+KOPPEL ORTHODONTICS

PATIENT INFORMATION

Patient Name: ______________________________ (Last / First / M.I.) ______________ (Name I prefer to be called) DOB: ______________

Address: ______________________________ (#/Street / City / State / Zip Code) Male ______ Female ______

Social Security #: ______________ E-mail Address: ______________

IF APPLICABLE:

School: ______________ Grade: ______ Hobbies/Interests: ______________

General Dentist: ______________ Approximate date of last visit: ______________

Patient lives with: ______________ Family members seen by Hall & Koppel: ______________

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

What is your primary concern/reason for your visit today? ______________

*****If parents/responsible parties are divorced/separated please indicate who is financially responsible.** ______________ ***

PRIMARY RESPONSIBLE PARTY

Name: ______________

DOB: ______ Relationship to Patient: ______

Social Security #: ______________

☐ *Check if address is same as patient address at top of page*

Address: ______________

Phone: (___) ______________ TYPE: *cell/home/work/other*

Phone: (___) ______________ TYPE: *cell/home/work/other*

Marital Status: ______ E-mail: ______________

Employer: ______________ Position: ______

Length of Employment: ______________

Please complete the following if applicable:

Spouse Name: ______________

DOB: ______ *Relationship to Patient:* ______

Phone: (___) ______________ *TYPE:* *cell/home/work/other*

Phone: (___) ______________ *TYPE:* *cell/home/work/other*

E-mail: ______________

Employer: ______________ *Position:* ______

Length of Employment: ______________

SECONDARY RESPONSIBLE PARTY

Name: ______________

DOB: ______ Relationship to Patient: ______

Social Security #: ______________

☐ *Check if address is same as patient address at top of page*

Address: ______________

Phone: (___) ______________ TYPE: *cell/home/work/other*

Phone: (___) ______________ TYPE: *cell/home/work/other*

Marital Status: ______ E-mail: ______________

Employer: ______________ Position: ______

Length of Employment: ______________

Please complete the following if applicable:

Spouse Name: ______________

DOB: ______ *Relationship to Patient:* ______

Phone: (___) ______________ *TYPE:* *cell/home/work/other*

Phone: (___) ______________ *TYPE:* *cell/home/work/other*

E-mail: ______________

Employer: ______________ *Position:* ______

Length of Employment: ______________

EMERGENCY CONTACT INFORMATION

Nearest relative/friend *not* living with you: ______________ Relationship to patient: ______________

Phone Number: ______________ Address: ______________ (#/Street / City / State / Zip Code)

Please Complete Back Side

MEDICAL HISTORY QUESTIONNAIRE

Please check all that apply to the patient

- ☐ Self conscious about teeth/smile
- ☐ Brush daily
- ☐ Learning disability
- ☐ Had a previous orthodontic evaluation
- ☐ Chipped/injured tooth/teeth
- ☐ Teeth sensitive to hot/cold
- ☐ Jaw fractures/cysts/mouth infections
- ☐ Bleeding gums/bad taste/mouth odor
- ☐ Thumb/finger habit (until age:_____)
- ☐ Abnormal swallowing habit (tongue thrust)
- ☐ Mouth breathing/snoring
- ☐ Relative with similar tooth/jaw relationship
- ☐ TMJ (temporomandibular joint) dysfunction
- ☐ Adenoids and/or tonsils removed (at age:_____)
- ☐ Tobacco use
- ☐ Hepatitis A/B/C
- ☐ AIDS or HIV positive
- ☐ Anorexia/bulimia
- ☐ Allergy to nickel/latex/plastic/dental anesthetic
- ☐ Bone fractures/major accidents
- ☐ Rheumatoid or arthritic diagnosis
- ☐ Endocrine/thyroid condition
- ☐ Kidney condition
- ☐ Diabetes
- ☐ Cancer/tumor/radiation/chemotherapy
- ☐ Stomach ulcer/hyperacidity
- ☐ Polio/mononucleosis/TB/pneumonia
- ☐ Compromised immune system
- ☐ Bleeding disorder/bruising tendencies
- ☐ Anemia
- ☐ High or low blood pressure
- ☐ Cardiovascular condition
- ☐ Frequent headaches/colds/sore throat
- ☐ Eye/ear/nose/throat condition
- ☐ Menstruation has begun
- ☐ Pregnant/may be pregnant

Further explanation of any of the above: ______________________________

Other pertinent medical or dental information: ______________________________

Medications currently being taken: ______________________________

Primary care physician name: ______________________ Phone number: ______________

DENTAL INSURANCE INFORMATION

(If Dental and/or Orthodontic Coverage, Please provide card)

Insured's Name: ______________________ Date of Birth: ____________ Social Security #: ____________

Employer: ______________________ Relationship to Patient: ______________________

Insurance Company: ______________________ Group #: ____________ ID #: ____________

Insurance Co. Address: ______________________________ Phone #: ____________

Do you have dual coverage? ☐ Yes ☐ No If yes, complete the following:

Insured's Name: ______________________ Date of Birth: ____________ Social Security #: ____________

Employer: ______________________ Relationship to Patient: ______________________

Insurance Company: ______________________ Group #: ____________ ID #: ____________

Insurance Co. Address: ______________________________ Phone #: ____________

I have read and understand the above questions. I will not hold Dr. J. Adam Hall or Dr. Harold J. Koppel or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to the afore-mentioned patient history record or medical/dental status, I will so inform Hall & Koppel Hot Springs Orthodontics.

Patient Signature: ______________________________ Date: ______________