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ORTHODONTICS AND DENTOFACIAL ORTHOPAEDICS FOR ADULTS & CHILDREN

Member American Association of Orthodontists

Patient Information

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

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

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext:** ___

Sex: □ Female □ Male **DOB:** _____ **Age:** _____ **Marital Status:** _____

Email: _____ **Social Security:** __ __ __- __ __- __ __ __ __

Who referred you to Dr. Hanan? _____

Pharmacy Information

Pharmacy Name: _____ **Pharmacy Phone #** _____

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

Responsible Party (If someone other than patient or if patient under 18 years of age)

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

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

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext:** ___

Sex: □ Female □ Male **DOB:** _____ **Age:** _____

Emergency Contact

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext:** ___

Primary Insurance Information (Dental)

Name of Insured: _____ **Relationship to Patient:** _____

Social Security or ID # _____ **Group #** _____ **DOB:** _____

Name of Employer: _____ **Name of Insurance Company:** _____

Secondary Insurance Information (Dental, if applicable)

Name of Insured: _____ **Relationship to Patient:** _____

Social Security or ID # _____ **Group #** _____ **DOB:** _____

Name of Employer: _____ **Name of Insurance Company:** _____

Dental History

Reason for Today's Visit: _____

Date of last dental care: _____ **Date of last dental x-ray:** _____

Former or current dentist: _____ **Do you floss? □ No □Yes If so how often:** _____

How often do you brush: _____ **Are you a Mouth Breather? □ No □Yes**

Do you snore? □ No □Yes Have you ever been diagnosed with TMJ? □ No □Yes

Have you ever been part of a sleep study? □ No □Yes If so when _____ **Dr's Name:**_____

Have you ever had molds of your teeth taken before? □ No □Yes

On a scale of 1-10 please rate your Gag Reflex (1 being NO Gag reflex and 10 being a hypersensitive Gag reflex) _____
Check all that apply:

□Bad breath	**□GERD**	**□Sensitivity when biting**
□Bleeding gums	**□Grinding teeth**	**□Sensitivity to Cold**
□Clenching Teeth	**□Headaches**	**□Sensitivity to Hot**
□Clicking Jaw	**□Jaw Pain**	**□Sensitivity to Sweet**
□Popping Jaw	**□Loose teeth or broken filling**	**□Sleep Apnea**
□Food collection between your teeth	**□Periodontal treatment**	**□Sores or growths in your mouth**

Is there anything else you would like to tell us that we haven't already asked?

_____

_____

_____

Is there anything we can do to make your visit more comfortable?

_____

_____

_____

Medications and Allergies

Are you currently taking any Medications? □ No □Yes If Yes:

Name	Dosage	How Often/ How Long

Are you Allergic to any Food or Medication?

_____

_____

Do you have Seasonal Allergies? □ No □Yes Explain, _____

Are you Allergic to □ Aspirin □ Epinephrine □ Latex □Sulfa □Other materials _____

Medical History

Physician's Name: _____ Date of Last Visit: _____

Have you ever had any serious illnesses or operations? □ No □Yes

If yes, describe: _____

Have you ever had a blood transfusion? □ No □Yes If yes, please give approximate dates _____

***Women Only*: Are you pregnant? □ No □Yes How Many Months _____ Are you nursing? □ No □Yes**

Are you taking birth control? □ No □Yes

Have you ever taken any medication from a group of drugs collectively referred to as "FEN-PHEN?" These include combinations of Ionimin, Adipex, Fastin (brands of phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine) □ No □Yes

Check if you have or even had any of the following:

o Anemia	o Circulatory Problems	o Heart Murmur	o MS	o Swelling of feet or ankles
o Arthritis, Rheumatism	o Cortisone Treatments	o Heart Problems	o Pacemaker	o Thyroid Problems
o Artificial Heart Valves	o Cough, Persistent	o Hemophilia	o Parkinson Disease	o Tobacco Habit
o Artificial Joints	o Cough up Blood	o Hepatitis A, B, C	o Radiation Treatment	o Tonsillitis
o Asthma	o Crohn's Disease	o High Blood Pressure	o Respiratory Disease	o Tuberculosis
o Back Problems	o Diabetes	o HIV/ AIDS	o Rheumatic Fever	o Ulcer
o Blood Disease	o Epilepsy	o Jaw Pain	o Scarlet Fever	o Venereal Disease
o Cancer	o Fainting	o Kidney Disease	o Shortness of breath	
o Chemical Dependency	o Glaucoma	o Liver Disease	o Skin Rash	
o Chemotherapy	o Headaches	o Mitral Valve Prolapse	o Stroke	

Other: _____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payed by insurance. I authorize the use of my signature on all insurance submissions.

The above- named dentist may use my health care information, and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining services and the determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or 1(one) year from the date signed below.

_____ _____
Signature of Patient, Parent, Gaurdian or Personal Representative Date

_____ _____
Please Print Name of Patient, Parent, Gaurdian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved